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Medical Services
ALGORITHM-DIRECTED TROOP MEDICAL CARE

Supplementation of this Regulation or establishment of forms other than U.S. Army Medical Command (MEDCOM) forms are prohibited without prior approval from the Office of the Assistant Chief of Staff (CoS) for Information Management, ATTN: MCHO-CL-C, 2748 Worth Road, JBSA Fort Sam Houston, TX 78234-6013. Utilization of a protocol system other than algorithm-directed troop medical care (ADTMC) cannot be used until approved by the U.S. Army Medical Command, ATTN: MCHO-CL-C, 2748 Worth Road, Fort Sam Houston, TX 78234-6010.

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*This pamphlet supersedes United States Army Medical Command (MEDCOM) Pamphlet 40-7-21, 23 June 2006.

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1. History. This issue publishes a major revision of this publication.

2. Purpose. This pamphlet serves as a guide to provide the unit commander responsible for the military treatment facility (MTF), with the advice of the supervising medical director and Installation Director of Health Services, standardized clinical protocols for use by medical screening personnel in determining the urgency and level of care that generally healthy active duty (AD), United States Army Reserve (USAR), and National Guard (NG) Soldiers and Cadets while serving on active duty or activated for training requires and, when appropriate, in providing minor treatment to them included in the minor-care protocols to the extent that DHA has not published superseding guidance. (Soldier(s) will be used to refer to the AD, USAR, and NG Soldiers and Cadets while serving on active duty or activated for training throughout the remainder of the document).

3. Explanation of abbreviations and terms. The glossary contains definitions of abbreviations and special terms used in this pamphlet.

4. Applicability. The protocols in this pamphlet will be used by enlisted medical personnel who screen generally healthy Soldiers in walk-in ambulatory care settings including Soldiers presenting for sick call. It is not intended for the screening of Soldiers that have been discharged from the hospital within the last month or have chronic systemic medical conditions (such as, pregnancy, diabetes, hypertension, hyperlipidemia, history of cancer, immunosuppression, or human immunodeficiency virus (HIV)).

5. Responsibilities.

a. The unit commander responsible for the MTF, with the advice of the supervising medical director and Installation Director of Health Services, will—

(1) Ensure that screeners are provided adequate supervision in accordance with paragraph 11 of this pamphlet and the screener's performance is evaluated by a physician, physician assistant, nurse practitioner, or other privileged provider.

(2) Ensure that the individual screener's competency with regard to evaluating, treating, and/or determining the disposition of sick call Soldiers is delineated in writing and that it is reviewed and/or revised at least every 2 years.

(3) Review the list of minor-care medications addressed in appendix C and approve a list of minor-care medications to be dispensed by the pharmacy when in a garrison environment or provided by the authorized screener under the supervision of his or her supervising privileged provider when in a field or deployed environment in accordance with paragraph 11.

(4) Ensure implementation of the safety and quality control requirements in paragraph 13 and appendix E of this pamphlet.

(5) Establish a local training program for screeners to include table of organization and equipment personnel when they function as screeners. Training will cover the requirements outlined in appendix G of this pamphlet.

(6) Ensure documentation of completed training in the screener's competency assessment file (CAF).

b. The medical treatment facility supervising medical officer will—

(1) Certify in writing that clinic personnel performing the screening function have received training and evaluation in the proper use of the ADTMC in accordance with appendix G of this pamphlet.

(2) Ensure training, retraining, and in-service education as necessary to support the overall program.

(3) Promote screener training by requiring supervising noncommissioned officers (NCOs) and supervising privileged providers to see Soldiers jointly with the screeners.

6. Background. The ADTMC serves several purposes within the Army Health Care System.

a. The ADTMC system provides rapid high-quality medical care to Soldiers. Screening by medical treatment facility personnel is a key component of the ADTMC system. When done properly, it ensures that Soldiers reporting to sick call are expeditiously routed to the appropriate level of care. When done improperly, it can harm the Soldier by providing him inappropriate treatment or directing him to an inappropriate level of care.

b. ADTMC also provides medics with further training in medical care of Soldiers. Medic familiarity with acute medical conditions is enhanced by the ongoing feedback they receive from supervisors and peers as part of the staffing and peer review processes. Increased knowledge of acute medical conditions better prepares medics for military missions in dispersed, austere environments.

7. Use of ADTMC

a. The treatment protocols in the ADTMC system are applicable to the care of the generally healthy Soldier.

b. The mission of screening is to gather important data about the Soldier's problem to be able to provide minor medical treatment in accordance with the treatment protocol

or refer Soldiers to the appropriate level of care under the delegated authority of the supervising privileged provider.

c. Screening begins when the Soldier walks into the primary care setting for a routine disease, non-battle injury complaint.

d. Screeners can render minor medical care, as incorporated in the protocols in this pamphlet, only in MTFs or sick call settings. The screener is allowed to write a one-time profile that is no longer than 72 hours in duration for a new condition that has not previously had an associated profile and is not related to pregnancy or wearing personal protective equipment (such as, body armor, Kevlar, gas mask, etc.). Profile must be cosigned by the supervising privileged provider in accordance with Army regulation (AR) 40-501.

e. The use of ADTMC (or other approved protocol system) is optional only when a physician, physician assistant, nurse practitioner, or other privileged provider provides the evaluation, treatment, and disposition of the Soldier.

f. ADTMC (or other approved protocol system) is used when screening personnel provide the evaluation, treatment, and/or disposition of sick call Soldiers when the supervising privileged provider is not physically present during the patient care encounter.

g. Screeners may be approved to provide the minor-care protocol medications addressed in appendix C under the supervision of his/her supervising privileged providers when in a field or deployed environment in accordance with paragraph 11. Additional medications requested by the supervising privileged provider for use at the local level are authorized, only if formal, documented training related to the safe and appropriate use of these medication has occurred and is approved by the local Pharmacy and Therapeutics Committee where appropriate and the unit commander responsible for the MTF. In a garrison clinic environment, medications will be dispensed by the pharmacy.

h. Documentation of the care provided by ADTMC screeners will be in the military healthcare system (MHS) electronic health record (EHR). The Common Core Tri-Service Workflow (TSWF) Form or equivalent MHS EHR form will be used to document within the MHS EHR. If access to the MHS EHR is not available, then the ADTMC screener may use Department of the Army (DA) Form 5181 (Screening Note of Acute Medical Care), in accordance with AR 40-66, and upload the document in the MHS EHR as soon as feasible.

i. Screening encounters will be coded using a 99499.

j. Safety and quality control measures will be conducted in accordance with AR 40-68, and appendix E of this pamphlet.

k. The basic premise of including treatment protocols is that generally healthy Soldiers requiring health care can often be effectively treated with self-care or a minor-care protocol.

l. Active feedback on screener performance by the supervising NCO and supervising privileged provider will increase the safe, quality care of Soldiers while increasing the medic knowledge of acute medical conditions which will better prepare him or her for his or her deployed missions.

8. Assignment of screeners

a. Screening personnel (enlisted medic) assigned for duty in various clinic settings are permitted to utilize the ADTMC (or comparable system) to screen generally healthy Soldiers walking-in for ambulatory care to include Soldiers presenting for sick call after they have been authorized by their supervising privileged provider.

b. Personnel assigned to a health care facility will not automatically be authorized to be screeners. Supervisors are responsible for the identification and evaluation of personnel considered as potential screeners during a competency validation period. Competency validation period is discussed in further detail in appendix G. After the supervising privileged provider has validated the competency of a medic, they can authorize them to be able to utilize ADTMC in a memorandum for record. See appendix E for further details.

9. Training. Screeners must complete a formal training program prior to being assigned to evaluate, treat, and/or make disposition of Soldiers who present for care in accordance with local policy and meets the requirements in appendix G of this pamphlet. Screener's full competency assessment must be documented within the screener's CAF every 2 years in accordance with appendix E of this pamphlet.

10. Supervision. Screeners will be supervised by a physician, physician assistant, nurse practitioner, or other privileged provider and a qualified supervising NCO who has been trained and has had this responsibility specifically delegated to them by the supervising provider.

a. Supervising NCO will meet the following requirements:

1) Completed a cumulative 480 hours of prior screening experience. 480 hours is equal to 40 hours per week for 12 weeks.

2) Competency in 68W 10-30 level skills.

3) Current in authorization to be an ADTMC screener.

b. Supervising privileged provider will delegate authority to a qualified NCO to act as the supervising NCO in a MFR. MFR will be placed in the supervising NCO's CAF.

11. Recording encounters.. Screeners will utilize the subjective, objective, assessment, plan and disposition (SOAP-D) format and document within the MHS EHR Common Core TSWF form or equivalent MHS EHR form when recording the Soldier's encounter. Minimal documentation requirements are the vital signs (such as, temperature, heart rate, blood pressure, respiratory rate, pulse oximetry if available, and pain level), chief complaint, history of present illness, current medications and any allergies, date of last menstrual period for all females, and medical readiness category (MRC) status and any delinquent readiness requirements, protocol to include pertinent positive and negative answers, and screening disposition to include any treatment and counseling provided. MRC status and delinquent examinations may be excluded if access to the electronic record is not readily available. Appendix D of this pamphlet provides special instructions for use with ADTMC. If the electronic forms cannot be accessed, then screeners will use DA Form 5181, in accordance with AR 40-66, to record acute medical screening encounters and uploaded into the MHS EHR as soon as feasible.

12. Quality and safety control.

a. Evaluation of screeners' performance will include an evaluation by a physician, physician assistant, nurse practitioner, or other privileged provider.

b. Screening activities of ADTMC (or comparable system) will be integrated into the local facility's process improvement structure. The process improvement activities will include that screenings are co-signed by the supervising privileged provider.

c. Peer reviews will be completed on a monthly basis for Soldiers who are working within the MTF for a period longer than 30 days. Appendix E of this pamphlet provides special instructions for use of peer reviews with ADTMC.

d. The supervisor will analyze the screenings and peer reviews on at least a monthly basis to look for patterns or trends related to specific performance issues for which additional training, education, or more formal corrective action may be required.

13. Flight/diving personnel: Personnel reliability program status.

a. When personnel on flight status are seen by a medic, advanced enlisted medic (AEM), or privileged provider that is not a flight surgeon, aviation medicine physician assistant, or aviation medicine trained nurse practitioner they must be counseled that they are not to perform flying duties until cleared by their flight surgeon, aviation medicine physician assistant, or aviation medicine trained nurse practitioner. When aircrews (aviation personnel) receive treatment, consult AR 40-8 to determine if the

aircrew member's unit commander should receive a recommendation for grounding, using DD Form 2992 (Medical Recommendation for Flying Duty or Special Operations Duty). Only a flight surgeon, aviation medicine physician assistant, or aviation medicine trained nurse practitioner may return aviation personnel to flying duty.

b. When diving personnel receive treatment from personnel other than a combat diving medical technician (CMDT) or dive medical officer (DMO), they should be evaluated by their CMDT or DMO prior to their next mission. Additional concern should be present when the medical condition applies to cardiovascular, respiratory, auditory, genitourinary, gastrointestinal, or musculoskeletal systems, sinuses, eyes, or ability to equalize air pressure.

14. Trade Names. The use of trade names in this pamphlet is for clarity only. It does not constitute endorsement by the Department of Defense. Screeners may not be as familiar with the generic names for some minor-care medications; therefore, to promote clarity, familiar brand names have been used in the medication reference (appendix B).

15. Local modification of protocols.

a. It is essential that we provide the highest quality health care to our Soldiers. This can be accomplished by our personnel being committed to strict adherence to the standardized protocols contained in this pamphlet. Personnel will not make modifications or changes to the protocols, treatment protocols and minor-care protocols (MCPs) except as described in subparagraph b below.

b. Screeners may modify the disposition category/level of care to meet local requirements without approval if the disposition category/level of care is to an equal or higher category/level of care than the category/level of care designated in the protocol.

16. Local reproduction of pamphlet. This pamphlet, including all parts, is authorized for local reproduction.

Appendix A References

AR 40-3

Medical, Dental, and Veterinary Care.

AR 40-8

Temporary Flying Restrictions due to Exogenous Factors

AR 40-66

Medical Record Administration and Health Care Documentation

AR 40-68

Clinical Quality Management

AR 40-501

Standards of Medical Fitness.

AR 600-9

The Army Body Composition Program

Defense Health Agency Interim Procedure Memorandum 18-001

Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs).

Defense Health Agency Procedural Instruction 6200.06

Periodic Health Assessment (PHA) Program

Department of Defense Manual (DODM) 6025.13

Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Healthcare System (MHS)

MEDCOM Regulation 40-50

Career Management Field 68 Clinical Baseline Competencies for Enlisted Medical Personnel Performing Direct Patient Care at the Military Treatment Facility

MEDCOM Policy Memo 18-007

Policy Guidance on Clinical and Administrative Management of Bone Stress Injury (BSI)

Soldier Training Publication (STP) 8-68W13-SM-TG

Soldier's Manual and Trainer's Guide MOS 68W, Health Care Specialist Skill Levels 1, 2 and 3.

U.S. Army Aeromedical Policy Letters and Aeromedical Technical Bulletins

*MEDCOM Pam 40-7-21

**Section I
Required Publications**

This section contains no entries.

**Section II
Related Publications**

This section contains no entries.

**Section III
Prescribed Forms**

This section contains no entries.

**Section IV
Referenced Forms**

Common Care for Tri-Service Workflow Form

DA Form 4700
MEDCOM OP 45

DA Form 5181
Screening Note of Acute Medical Care

DD Form 2992
Medical Recommendation for Flying Duty or Special Operating Duty

SF 600
Standard Form 600

Appendix B
 Screener's Manual Protocols

1. Possible dispositions from decision points of the screening protocols are summarized as follows:

CATEGORY/LEVEL

PROVIDER SKILL LEVEL

I. Provider Now

A medical condition exists which has the potential to be a life-threatening (an emergency) requiring the immediate attention of a privileged provider or involves moderate risk to the Soldier associated with the required medical decision making. Initiate emergency treatment as necessary, contact nearest available privileged provider, and immediately transport to the closest appropriate facility as necessary. Immediate care for these Soldiers is often required in a facility with more capabilities than a battalion aid station.

II. Advanced Enlisted Medic Now

A medical condition exists which requires a more experienced, qualified provider to evaluate the condition. Findings will be recorded in the MHS EHR Common Core TSWF form or equivalent MHS EHR form. Data will be obtained by an ADTMC screener, but the experience, qualified provider will ultimately make the disposition. Experienced, qualified provider is defined as an expeditionary combat medic, special operations medic, flight paramedic, or supervising NCO when local policy supports the delegation of authority from the supervising privileged provider to the supervising NCO for the associated task. If the AEM is not available, then the Soldier will be seen by the supervising privileged provider.

III. Minor-Care Protocol (MCP)

A medical condition exists for which minor-care within the scope of the screener is appropriate. The instructions and medications to be offered to the Soldier are contained within the body of the protocol. The screener will review the Soldier with his or her supervising NCO prior to

disposition. ANYONE MAY ELECT TO OVERRULE THE RECOMMENDATION OF MINOR CARE. If the MCP is overruled, the Soldier will be dispositioned to the next higher level/ category of care.

IV. Specialty Referral

A medical condition exists which can be appropriately evaluated in a specialty clinic that accepts self-referrals (nutrition, physical therapy, behavioral health, dental, wellness center). Consultation with either the supervising NCO or supervising privileged provider is required prior to referring the Soldier to the specialty clinic.

NOTE TO SCREENER: IF FOR ANY REASON YOU AS THE SCREENER FEEL THAT THE DISPOSITION OF THE SOLDIER AS DETERMINED BY THE PROTOCOL IS INAPPROPRIATE, CONTACT THE SUPERVISING PRIVILEGED PROVIDER OR SUPERVISING NCO. RULE OF THUMB: WHEN IN DOUBT, REACH OUT FOR HELP! IT IS BETTER TO OVER REFER SOLDIERS TO THE SUPERVISING PRIVILEGED PROVIDER OR SUPERVISING NCO THAN TO TAKE THE SLIGHTEST CHANCE THAT THE SOLDIER IS NOT SCREENED TO THE APPROPRIATE CATEGORY/ LEVEL OF CARE.

2. Questions concerning the disposition instructions for any particular Soldier should be referred to the supervising privileged provider who is the responsible individual for all aspects of medical care within the unit.

3. The medications to be reviewed and considered for approval by the unit commander responsible for the MTF and dispensed by the pharmacy in a garrison clinic environment or provided by the screener in a field or deployed environment under the supervision of his or her supervising privileged provider in conjunction with the MCPs are contained in Appendix B. Substitution of generic equivalent medications is permitted by the supervising privileged provider or dispensing pharmacy; however, this does not constitute authority for the addition or deletion of any categories of minor-care medications.

ADDITIONAL SOLDIER CARE NOTES:

1. This document is intended for the screening of generally healthy Soldiers to determine the urgency and level of care that they require and provide minor treatment as required under supervision of a supervising NCO and provider. Soldiers that have been discharged from the hospital within the last month, have chronic systemic medical conditions (like pregnancy, diabetes, hypertension, hyperlipidemia, history of cancer, immunosuppression, HIV) should be considered for referral to the supervising provider.

2. Any Soldier that is found to have abnormal vital signs should be referred to the supervising medical provider. It is recognized that different studies have defined the normal range for vital signs differently. For the purpose of ADTMC screening, the following vital sign ranges will be used for the Soldier.

a. Normal range for temperature is 97.8-99°F. For ADTMC Screening, an abnormal temperature is a temperature of 100.4 °F or greater or a temperature of 97.0°F or less.

b. Fever: Temperature equal to or greater than 100.4.

c. During outbreaks of acute respiratory disease, basic trainees with temperatures greater than 100°F will be treated in accordance with local standing operating procedures (SOPs). The period most commonly associated with this problem is January through May; however, outbreaks may occur at any time.

d. Normal range for an adult heart rate is 60-100 beats per minute (bpm) depending on the person's physical condition and age. An adult athlete in good physical condition can have a heart rate less than 60 bpm. For ADTMC screening, an abnormal heart rate is a rate below 60 bpm, above 90 bpm, or that increases by 20 or more bpm upon going from sitting to standing.

e. Normal range for an adult respiratory rate is 12 to 18 breaths per minute. For ADTMC screening, an abnormal respiratory rate is a rate of 8 or less or rate over 20.

f. Normal range for an adult pulse oximetry is 95-100%. For ADTMC screening, an abnormal pulse oximetry is below 93%.

g. Normal range for an adult blood pressure is less than 120 systolic /80 diastolic. For ADTMC screening, an abnormal blood pressure is a blood pressure of 130/80 or higher, 100/60 or lower with symptoms (lightheadedness, dizziness, unsteady gait, confusion), or that decreases by 20 points systolic or 10 points diastolic a few minutes after going from sitting to standing.

h. Pain score utilizing the Defense and Veterans Pain Rating Scale of a level 5 and 6 is moderate pain, and a level 7 to 10 is severe pain. All Soldiers with moderate (5 or 6) pain level will be screen by at least the supervising AEM. All Soldiers with a severe (7 to 10) pain level will be screened by the supervising medical provider.

3. Every female Soldier should have their last menstrual period (LMP) documented as part of the screening. When the LMP is over 28 days ago, then the provider will be contacted. Although some forms of birth control can delay the menstrual period, the supervising provider will need to determine if the Soldier can continue to be screened by the medic or if additional pregnancy screening is required (pregnancy test) prior to development of the medical plan.

4. ANY SOLDIER RETURNING TO THE MTF FOR THE SAME COMPLAINT WILL BE REFERRED TO THE NEXT HIGHER LEVEL OF CARE THAN HE OR SHE WAS PREVIOUSLY SCREENED FOR OR THE LEVEL THAT HE OR SHE SCREENS TO ON FOLLOW-UP, WHICHEVER IS HIGHER. NO MATTER WHAT LEVEL THE SOLDIER IS SCREENED TO, THE SUPERVISING PRIVILEGED PROVIDER MUST BE CONSULTED AS PART OF THE DISPOSITION PRIOR TO THE SOLDIER LEAVING THE SCREENING AREA.

5. Prior to providing a medication, the screener will review the Soldier's allergies, medications, the last menstrual period of a female, the medication indications, contraindications, and potential side effects and instruct the Soldier on how to take the medication to include the indication, amount, frequency, route, and potential side effects.

6. First aid measures indicated will be performed by trained personnel.

7. When laboratory studies or x-rays are indicated, local SOPs, clinical staff standard protocols (CSSPs) or local protocols to include ADTMC will be utilized to allow the ADTMC screener the ability to enter orders for the supervising privileged provider. Screener will notify the supervising privileged provider that the protocol requires an order prior to placing it in the MHS EHR to allow the supervising privileged provider the opportunity to examine the Soldier or discuss the case with the screener or supervising NCO prior to entering the order. Supervising privileged provider will be responsible for following-up on the results of any laboratory or radiology studies that are ordered to include the follow-on care or public health tracking/ notification that is necessary due to the results of a study. Laboratory studies, radiology studies, and prescription medication orders will be signed by the supervising privileged provider as soon as feasible to prevent any delays in the Soldier's care.

8. The partial differential diagnosis, red flags and activity modifications are listed at the top of each protocol.

9. Procedures that require privileging (for example, setting fractures, minor surgery, etc.) will be accomplished only by personnel appropriately trained and privileged in accordance with MEDCOM Regulation 40-50, Army Regulation 40-68, and appropriate DHA policy.

10. Red Flags that are listed in the upper middle of each protocol. If a Soldier screens positive for a Red Flag or has an abnormal vital sign, then the Soldier will automatically be classified as Provider Now.

11. The closest qualified or privileged provider of a higher level should be engaged to assist with the care of all Provider Now triaged Soldiers. The privileged provider may change the screening category of the Soldier based on his or her scope and clinical judgement.

12. The following key will be used for all ADTMC protocols:

- ◇ Diamond will be a decision point (DP). A decision point is where the screener has to make a decision about how to proceed within the protocol.
- Oval will be an action like a physical exam or test to be performed by the screener.
- ▲ Triangle will indicate the utilization of an additional screening protocol.
- Stop Sign will indicate a screening disposition.

13. Protocols have been reviewed in accordance with MEDCOM Regulation 40-50, and STP 8-68W13. Specific tasks that support each protocol have been delineated.

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SORE THROAT/HOARSENESS, A-1

A sore throat is often due to a viral infection. Bacterial infections and other causes need to also be considered.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” One-sided severe sore throat with fever, trouble swallowing as shown by drooling, uvula displacement, hoarseness (hot potato voice), trismus (lock jaw), and enlarged, tender tonsils are signs of a deep neck space infection like a peritonsillar abscess. Shortness of breath and stridor are signs of upper airway obstruction due to severe pharyngeal inflammation.

DP1. Symptoms greater than 10 days, immunosuppression, inhaled steroid medications are related to diseases that are unlikely to go away without treatment. Hoarseness longer than 2 weeks requires a full laryngeal exam.

DP2. 4 questions that look at the chance of having a Group A Streptococcal (GAS) infection. If 3 of the questions are positive, there is 32% chance of having GAS and a rapid antigen test (RADT) should be performed. The RADT is effective for ruling out GAS in adults but some Soldiers with GAS are missed. Culture test is performed when the RADT is negative and Soldiers or their contacts are at higher risk for complications from a GAS infection. Culture generally takes 24-48 hours for the results to return.

TREATMENT PROTOCOL, A-1

Other protocols. Sore throat and hoarseness that are associated with a virus should be treated with minor-care. The other symptoms should be treated according to their associated protocols.

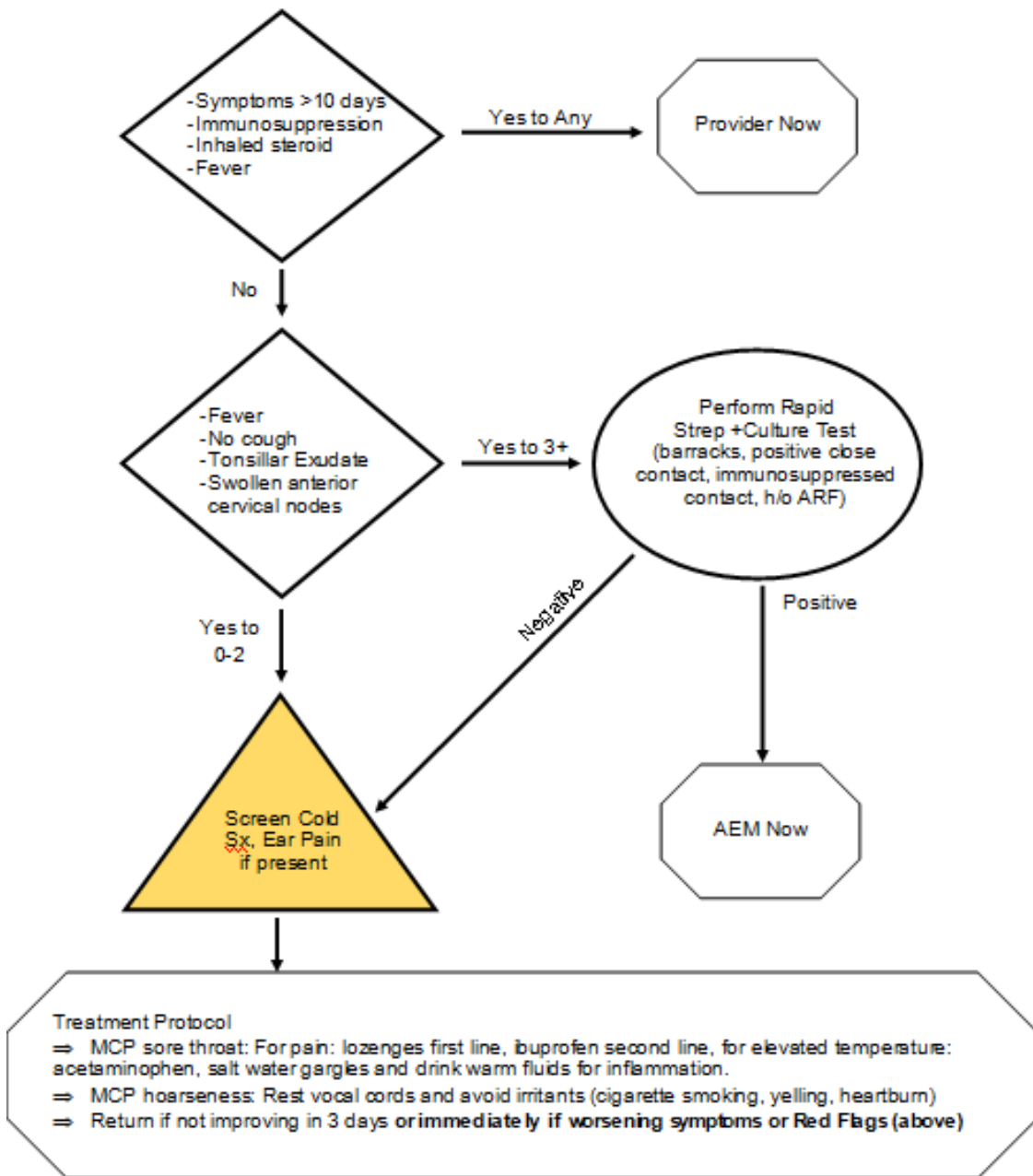
MCP for sore throat. A sore throat is often due to a viral infection. Minor-care consist of pain control, measures to decrease inflammation, getting plenty of rest and drinking plenty of fluids (water). Return for signs of the infection getting worse or progressing.

MCP for hoarseness. Hoarseness is often due to a virus or irritant. Minor-care consists of resting the vocal cords and avoidance of irritants (cigarette smoking, yelling, heartburn, post-nasal drip). This is a good opportunity to discuss the negative effects of tobacco use and encourage the Soldier to quit using tobacco, if applicable.

A-1: In accordance with MEDCOM Regulation 40-50		
Obtain a Throat Culture	pg.68	(13)
A-1: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform a head, eyes, ears, nose, and throat (HEENT) Exam	081-833-0254
Subject Area 6: Primary Care	Provide Care for Common Throat Infections	081-833-0243
Subject Area 15: Primary Care (SL2)	Obtain a Throat Culture	081-833-0248

SORE THROAT/HOARSENESS, A-1

Partial Differential Diagnosis Viral Infections Bacterial Infections Meningitis Neck Deep Tissue Infection Candida Infection Strep Throat	RED FLAGS Shortness of Breath Stridor Deviated Uvula Drooling/Trouble Swallowing Stiff Neck	Activity Modification: None
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EAR PAIN/DRAINAGE/TRAUMA, A-2

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” A stiff neck and fever are signs of meningitis, and all Soldiers with signs of meningitis should be seen by a privileged provider as soon as possible. Mastoid symptoms can be a sign of mastoiditis.

DP1. Signs of infection. All Soldiers with otitis media or moderate to severe otitis externa should be evaluated by a privileged provider to be considered for antibiotics.

DP2. Vertigo requires an internal ear evaluation. Longer timeline and decreased hearing can be signs of a complication from an ear infection or alternate cause requiring a qualified provider evaluation.

DP3. Evaluate for cold symptoms and sore throat that can be associated with ear pain with their respective protocols.

TREATMENT PROTOCOL, A-2

Mild otitis externa, temporal-mandibular joint (TMJ) dysfunction, and ear pain with normal exam should be treated with minor-care.

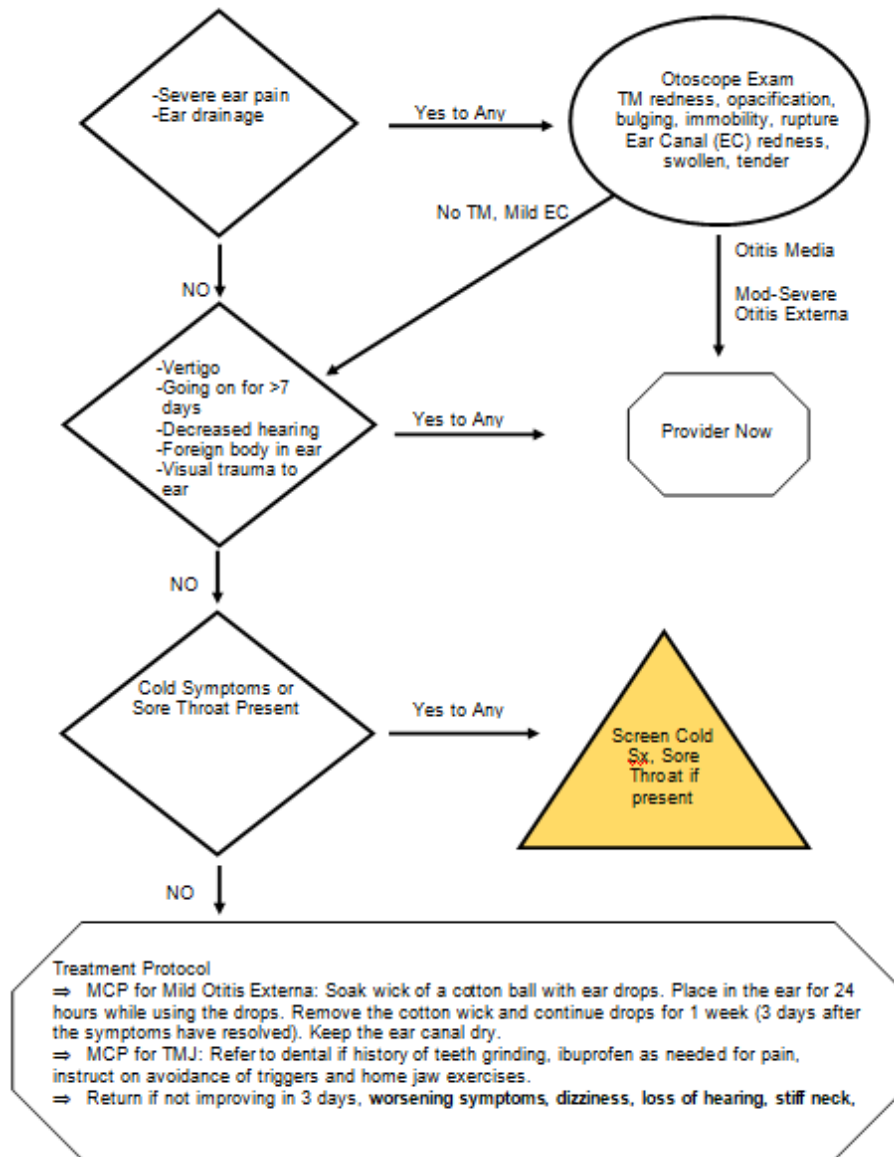
MCP for otitis externa. Soak wick of a cotton ball wick with OTC ear drops. Place in the ear for 24 hours while using the drops. Remove the cotton wick and continue drops for 1 week (3 days after the symptoms have resolved). Keep the ear canal dry. Use OTC ibuprofen as needed for pain. Return to clinic if not resolved in 1 week or worsening symptoms to include pain or fever.

MCP for TMJ is another common cause of pain around the ear. Evaluation includes seeing if the pain increases with opening and closing the jaw while placing the finger on the anterior inside of the ear to feel the joint. Ensure pain is not related to the heart. Use OTC ibuprofen for inflammation and pain. Refer to dental if history of teeth grinding. Instruct on avoidance of triggers (excessive chewing, chewing gum). Home therapy is jaw isometric exercises: jaw is open 1 inch and jaw is pushed 1) down against a loosely fist hand and 2) forward against a hand for 5 seconds each, each set is repeated 5 times per session with 3 sessions per day. Return if not improving within three days.

A-2: In accordance with MEDCOM Regulation 40-50		
Administer Otic Medications	pg.67	(3)(b)
A-2: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform a HEENT Exam	081-833-0254
Subject Area 6: Primary Care	Provide Treatment for Common Ear Infections	081-833-0241
Subject Area 18: Medication Administration	Administer Ear Medications	081-833-0020

EAR PAIN/DRAINAGE/TRAUMA, A-2

<p>Partial Differential Diagnosis Otitis Media/Externa Eustachian tube dysfunction Nasopharyngeal pathology Deep space head/neck infections Meningitis Mastoiditis Ruptured Ear Drum TMJ Dysfunction</p>	<p>RED FLAGS - Stiff Neck AND Fever - Posterior Ear Pain and/or Mastoid Erythema</p>	<p>Activity Modification: Otitis Externa -Avoidance of situations requiring utilization of ear plugs -No swimming Eustachian Tube Dysfunction -No scuba diving</p>
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COLD SYMPTOMS/ALLERGIES/COUGH, A-3

If a Soldier states that they have a cold, determine what complaint to screen by asking, “What do you mean by a cold?” If his/her complaint can be screened by another protocol, use that protocol.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Shortness of breath and abnormal pulse oxygenation suggest respiratory compromise. The soldier should be immediately started on oxygen pending further evaluation. Fever with a stiff neck suggests meningitis. Quick Sequential (sepsis-related) Organ Failure Assessment (qSOFA) is comprised of a respiratory rate greater than 21, systolic blood pressure less than 101, and Glasgow coma scale less than 15. Coughing up blood clots or quarter sized amounts of blood can be a sign of bleeding within the lungs.

DP1. Soldier with an ongoing productive cough may be contagious and needs to be evaluated for quarters. Viral symptoms that are improving and then get worse or onset of severe pain over the cheekbones/back upper teeth (sinuses) can be a sign of a sinus problem requiring prescription medications.

DP2. Purulent material is thick, yellow/greenish, foul smelling nasal discharge. Purulent discharge can be a sign of an infection or a retained foreign body in the nose. If symptoms have been going on for over seven days, evaluate for a bacterial infection.

TREATMENT PROTOCOL, A-3

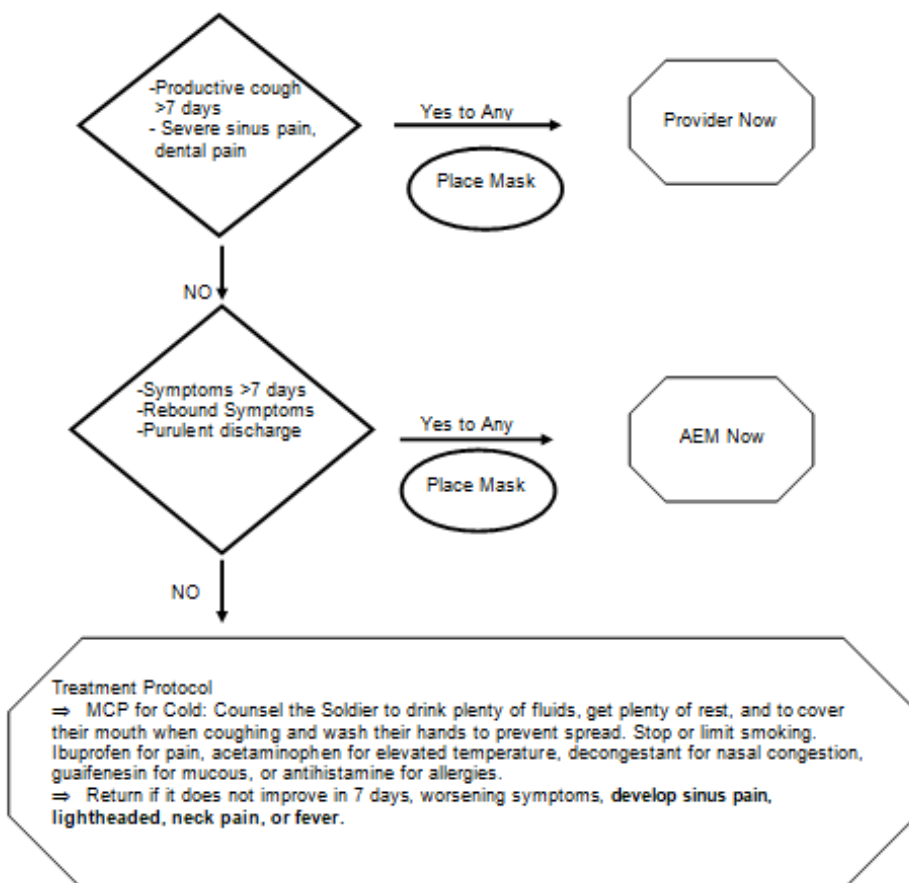
Most upper respiratory tract infection symptoms which include sore throat and ear pain are caused by a virus or allergies and do not require antibiotics. Minor-care is focused on improving the symptoms that the Soldier is having while the issue resolves on its own.

MCP Cold: Counsel the Soldier to drink plenty of fluids and rest, cover their mouth when they cough and wash hands to prevent spread. Ibuprofen for pain, acetaminophen for elevated temperature, decongestant for nasal congestion, guaifenesin for mucous, or antihistamine for allergies. Return to clinic if not improving within 1 week, worsening symptoms, **fever, new sinus pain, lightheadedness, or pain in the neck.**

A-3: In accordance with MEDCOM Regulation 40-50		
Administer Antihistamines	pg.67	(3)(j)
Administer Allergy Shots/Skin Testing	pg.67	(2)
Provide Oxygen	pg.69	(2)(h)
A-3: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform a HEENT Exam	081-833-0254
Subject Area 6: Primary Care	Provide Treatment for Sinus Infections	081-833-0242
Subject Area 6: Primary Care	Provide Care for Common Throat Infections	081-833-0243
Subject Area 6: Primary Care	Provide Care for Common Respiratory Disorders	081-833-0245

COLD SYMPTOMS/ALLERGIES/COUGH, A-3

Partial Differential Diagnosis Allergic or seasonal rhinitis Bacterial pharyngitis or tonsillitis Acute bacterial rhinosinusitis Influenza Pertussis	RED FLAGS - Abnormal Vital Signs - Shortness of Breath - Stiff Neck - Altered Mental Status - Coughing up blood clots or frank blood	Activity Modification: -Consider quarters/contagious precautions while febrile
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RINGING IN THE EARS/HEARING PROBLEM, A-4

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Altered mental status is a sign of a more serious underlying problem. Ear trauma can also result in a concussion that needs to be evaluated further. Focal neurological symptom/sign require further evaluation.

DP1. Ringing greater than 24 hours or related to an event requires further evaluation. Vertigo or “room-spinning dizziness” can be a symptom of inner ear problems and is often associated with nausea. Distinguish vertigo from light-headedness which is screened separately.

DP2. Trauma and blast injuries can result in Tympanic Membrane or inner ear problems. Foreign body or excessive wax within the ear canal can result in reversible hearing loss. If excessive wax is present, discuss removal with supervisor.

DP3. If the ringing noise is an associated symptom of a cold or flu, it should be screened by the protocol that addresses that primary complaint. Ringing in the ears, if without loss of balance, is not uncommon especially following recent exposure to loud noises from situations such as weapons firing or riding in mechanized vehicles or aircraft. Generally, the ringing in the ears associated with such noises subsides within 24 hours, but may persist in persons who have long histories of exposure. Further examination is indicated in the absence of exposure to excessive noise or for symptoms lasting longer than 24 hours. Ringing in the ears, if without loss of balance, can be associated with certain medications such as aspirin, nonsteroidal anti-inflammatory agents, some diuretics, etc. It is also important to check for hearing on the follow-up visit.

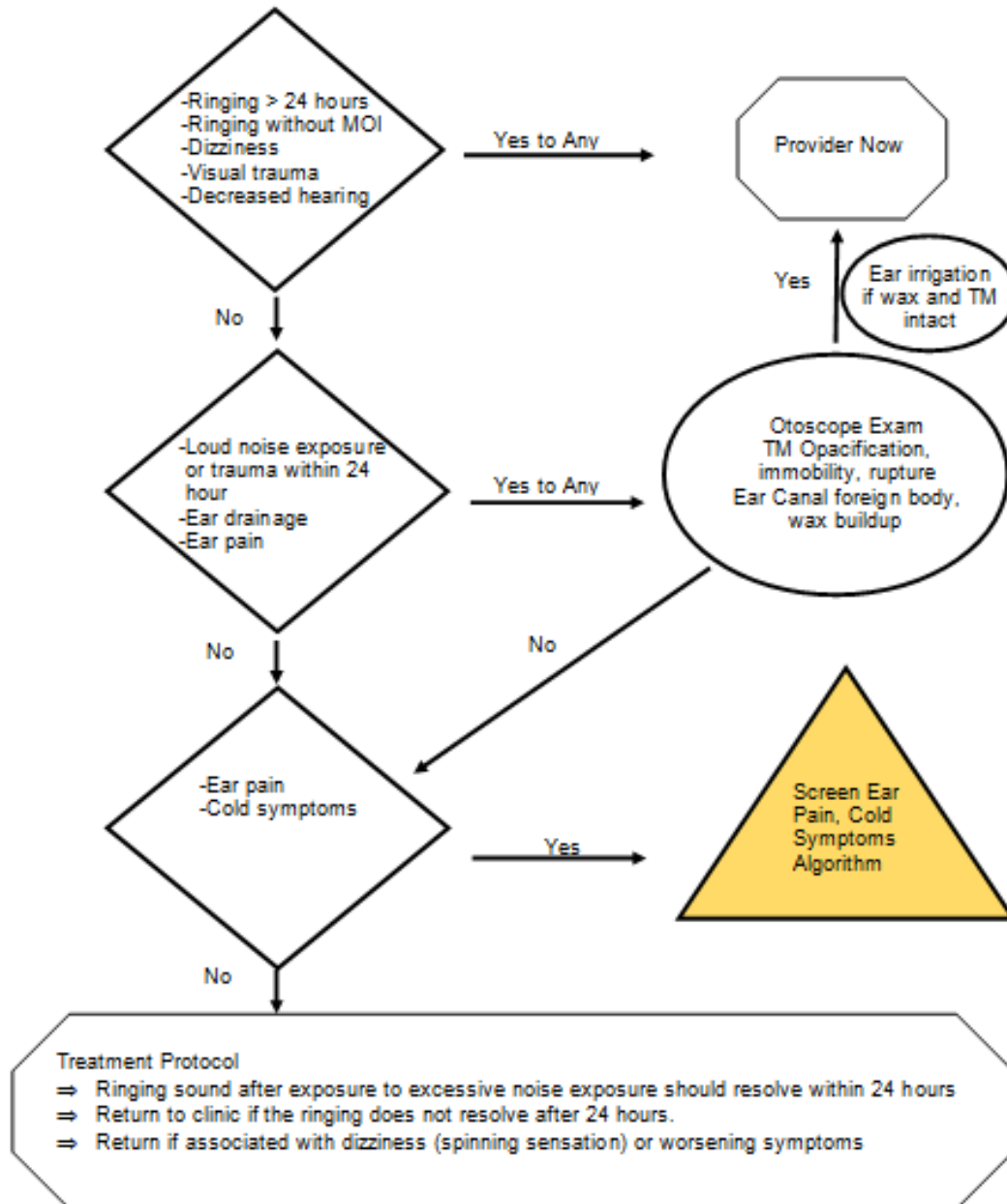
TREATMENT PROTOCOL, A-4

MCP. Tinnitus due to recent noise exposure should show improvement over the next 24 hours. Stress the importance of utilizing correct fitting hearing protection. Instruct the Soldier to return for medical assistance if ringing does not improve or if dizziness, ear pain, or hearing loss develops. Temporary sensation of hearing loss can be due to colds or ear infections. Soldiers with upper respiratory infection symptoms should be screened according to those protocols.

A-4: In accordance with MEDCOM Regulation 40-50		
Administer Otic Medications	pg.67	(3)(b)
A-4: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform a HEENT Exam	081-833-0254
Subject Area 6: Primary Care	Provide Treatment for Common Ear Infections	081-833-0241
Subject Area 15: Primary Care	Irrigate an Obstructed Ear	081-833-0059
Subject Area 18: Medication Administration	Administer Ear Medications	081-833-0020

RINGING IN THE EARS/HEARING PROBLEM, A-4

Partial Differential Diagnosis Cerumen Impaction Otitis Media Otosclerosis Ruptured Ear Drum Eustachian Tube Dysfunction Hearing Loss Disorders of the Jaw Joint Severe Anxiety Neck Injuries	RED FLAGS - Altered Mental Status - Focal Neurological Symptom or Sign - Dizziness	Activity Modification: -Avoid loud noise exposure x48 hours
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NOSE BLEED/NOSE TRAUMA, A-5

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Orthostatic hypotension is a sign of volume depletion and can represent a significant amount of blood loss.

Action1. Nosebleeds normally result from the rupture of small blood vessels inside the nose related to mucosal trauma (nose picking) or irritation (dry climate, blowing nose). 90% occur in the front of septum in the nose and can be controlled by applying external pressure. If the bleeding does not stop, then the nosebleed likely is coming from the back of the nose and needs to be controlled by a privileged provider.

DP2. Soldiers who have had trauma to the nose with an associated nosebleed require further screening. A misaligned broken nose can affect the upper airway and increase the risk of future sinus infections. Other injuries can be associated with the force that caused the trauma and nosebleed. Nosebleed while on anticoagulants can make it more difficult to stop a nosebleed and be a sign that the anticoagulation level is too high. Purulent discharge can be related to a retained foreign body or a concurrent infection that requires additional treatment. Recurrent nosebleeds not associated with a cold can be a sign of a bleeding disorder.

DP3. Cold symptoms often result in nosebleeds from recurrent blowing of the nose, rubbing the nose with a tissue after blowing it, picking the nose from congestion, and prominent blood vessels from allergies or inflammation. Soldiers with symptoms of runny nose, congestion, or allergies should be screened with the cold symptoms protocol.

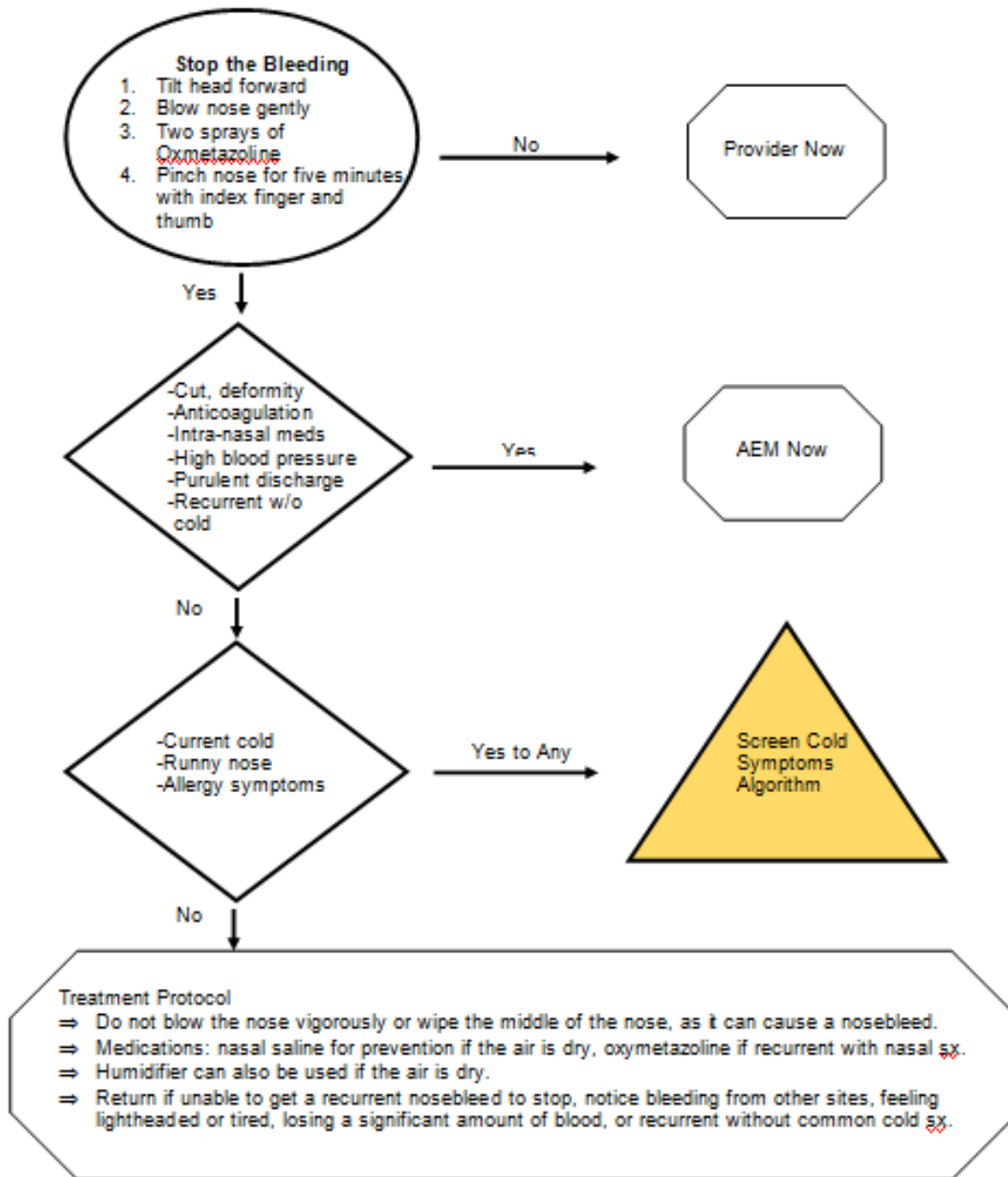
TREATMENT PROTOCOL, A-5

MCP Nosebleed. Once the bleeding is controlled, tell the Soldier to avoid vigorous blowing of the nose. If the room air is dry a humidifier or vaporizer often helps. Instruct the Soldier to return for medical assistance if the bleeding recurs and is not able to be controlled with tilting the head forward and applying external pressure with the thumb and index finger for 5 minutes or if the amount of blood lost at one time is enough to soak a wash cloth (ask the Soldier to bring in his wash cloth). Saline nasal spray can be used to prevent future nosebleeds if the air is dry after the initial nosebleed has resolved. Decongestant (Oxymetazoline) can be used to constrict the blood vessels.

A-5: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform a HEENT Exam	081-833-0254

NOSE BLEED/NOSE TRAUMA, A-5

Partial Differential Diagnosis Upper Respiratory Infections Allergic or Viral Rhinitis Trauma Bleeding Disorder Foreign Body	RED FLAGS - Airway Compromise - Orthostatic Hypotension - Bleeding from Gums - Inability to Move Eye	Activity Modification: -None
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BACK PAIN, B-1

Red Flags/DP1. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.”

DP1. A focused history and physical exam is essential to localizing a Soldier’s complaint of back pain and identifying its source. The HPI should include an OPQRST evaluation of the complaint and the ROS should specifically address red flag symptoms as well as questions related but not limited to infection, trauma, cardiopulmonary, gastrointestinal, and genitourinary, or gynecological complaints.

DP2. Back pain associated with pain, numbness, or tingling running down into the legs may represent central or peripheral nerve impingement and requires further evaluation. Refer to a physical therapist if direct referral is available locally.

TREATMENT PROTOCOL, B-1

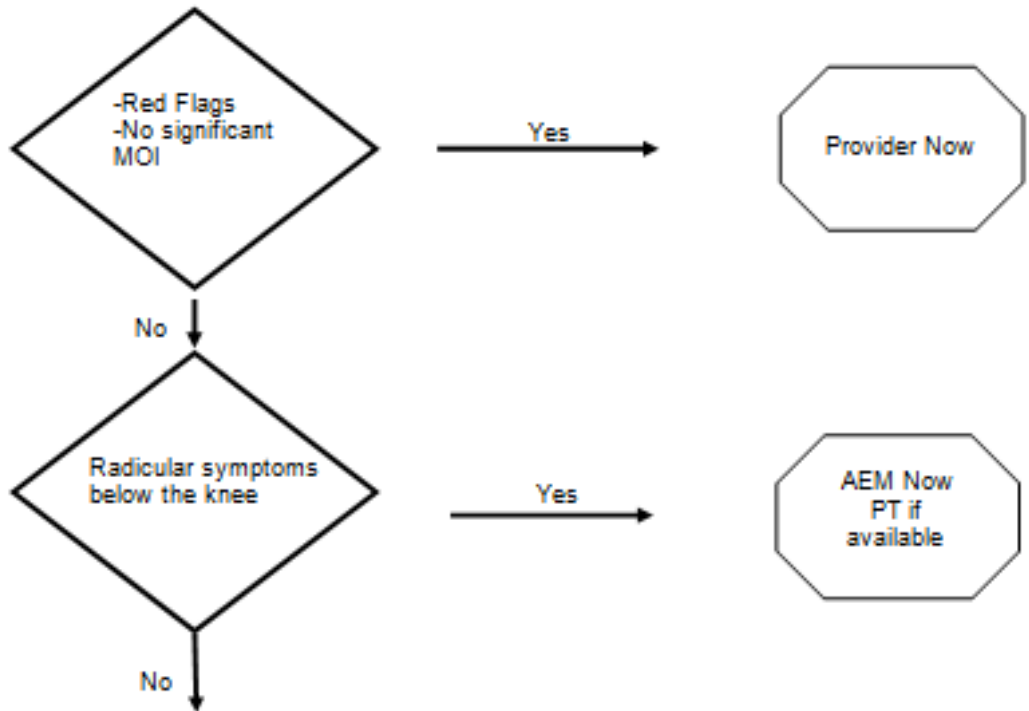
MCP Low back pain (LBP). LBP is extremely common in Soldiers. The best treatment is conservative measures including a home exercise program for mobilization and strengthening, ice and heat as needed for inflammation, and pain control with analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Follow established local protocols for home exercise that focus on stretching the lower back and hamstrings multiple times per day, strengthening the core muscles daily, and pain control as needed. Often obesity is a factor in low back pain and Soldiers should be encouraged to lose weight. Instruct the Soldier to seek medical assistance if pain becomes severe enough to prevent performance of normal duties/activities, worsening of other symptoms, symptoms last longer than one week.

If direct access to physical therapy (physical therapy sick call) is available, consider direct referral to physical therapy in accordance with local policy.

B-1: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-1: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222

BACK PAIN, B-1

Partial Differential Diagnosis Muscle Sprain/Strain Fracture Infection Renal Stone/UTI Arthritis Cauda Equina Syndrome	RED FLAGS - Fever - Saddle Anesthesia - Urinary Retention/Incontinence - Fecal Incontinence - Motor Deficits - Trauma with Vertebral Tenderness or Neuropathy - Dysuria/Frequency - Chest/Abdominal Pain	Activity Modification: - No repetitive bending or lifting but may lift/ carry up to 40lbs - Perform stretching, core strengthening home regiment during PT - No ruck marching, running, or jumping but may walk, bike, or swim for cardio
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Treatment Protocol

- ⇒ Provide home exercise program, activity modification as appropriate
- ⇒ Intermittent ice or heat IAW local protocol for inflammation
- ⇒ Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain as needed
- ⇒ Refer to PT if direct access is available
- ⇒ Follow-up: Immediate follow-up for a DP1 or DP2 symptoms. Routine follow-up is recommended for any symptoms that do not improve or worsen.

NECK PAIN, B-2

Red Flags/DP1. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Bony step off and midline tenderness can be signs of a vertebral fracture. Inability to flex the neck can be a sign of meningitis or fracture. Recent head, eyes, ears, nose, and throat (HEENT) or dental infection can have progressed to a more serious infection.

Action 1. In the setting of trauma, immobilize the head and neck and support ABCs as required, then transfer care to a privileged provider.

DP2. Neck pain associated with pain, numbness, or tingling running down into the shoulder or arms may represent central or peripheral nerve impingement and requires further evaluation. Refer to physical therapy if direct referral is available locally.

TREATMENT PROTOCOL, B-2

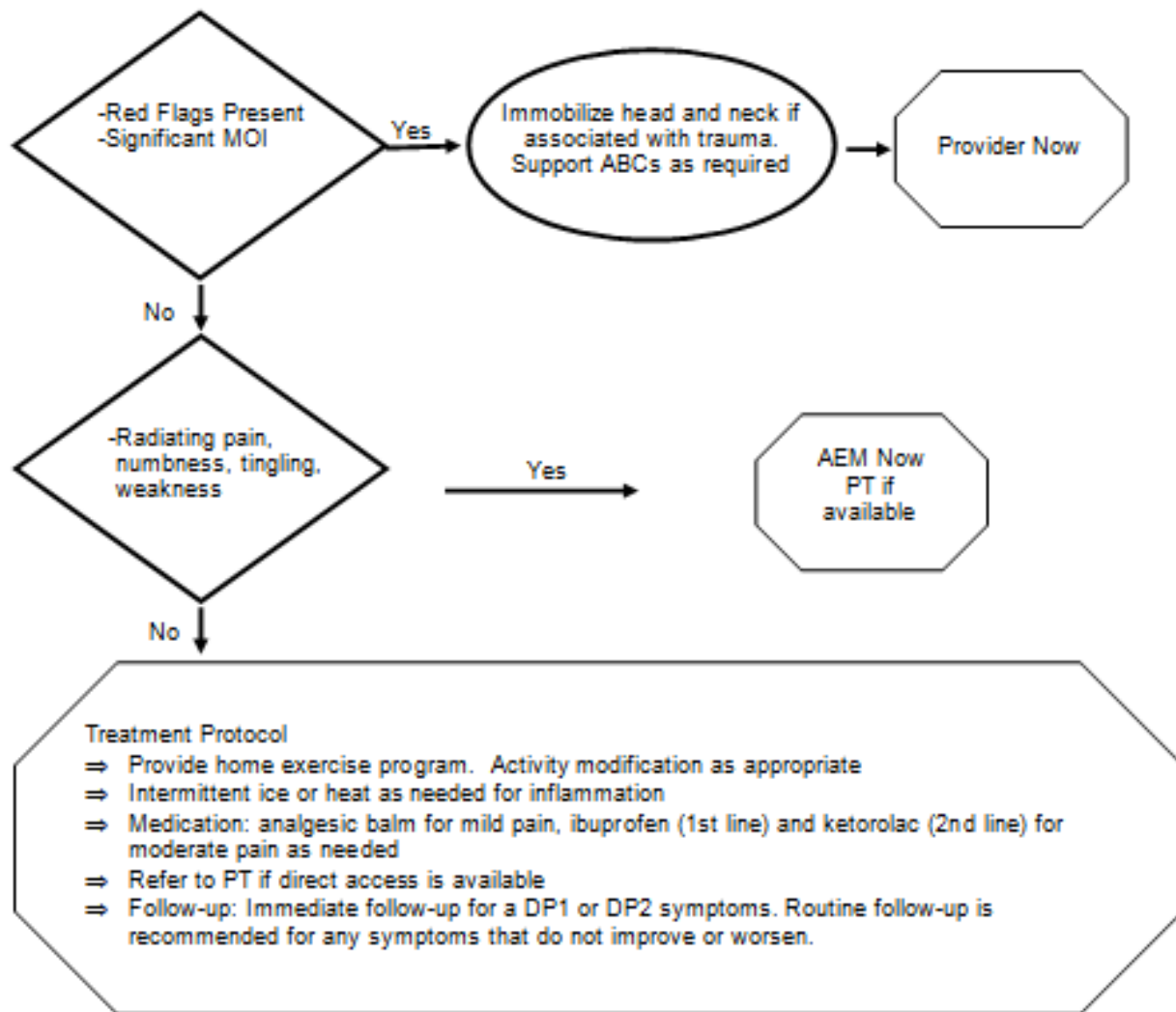
MCP. Neck pain is extremely common in Soldiers. The best treatment is conservative measures including a home exercise program for mobilization and strengthening, ice and heat as needed for inflammation, and pain as needed. A temporary profile may be required. Instruct the Soldier to work the neck through its range of motion at least twice each day to preserve mobility. This should ideally be done after a 20-minute application of ice. The range of motion exercise should not be vigorous enough to cause pain. Follow established local protocols for home exercise. Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Instruct the Soldier to seek medical assistance if pain becomes severe enough to prevent performance of normal duties/activities, worsening of other symptoms, symptoms last longer than one week.

If direct access to physical therapy (physical therapy sick call) is available, consider direct referral to physical therapy in accordance with local policy.

B-2: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-2: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222
Subject Area 3: Trauma Treatment	Initiate Treatment for Neck Wounds	081-833-0091
Subject Area 3: Trauma Treatment	Apply a Cervical Collar	081-833-0177
Subject Area 3: Trauma Treatment	Apply a Long Spine Board	081-833-0181

NECK PAIN, B-2

Partial Differential Diagnosis Muscle Strain Fracture Meningitis Flu Deep neck space infection	RED FLAGS - Bony step off/midline tenderness to palpation - Inability to flex neck - Fever - Recent HEENT or dental infection	Activity Modification: - No rucking or jumping - Consider limiting Kevlar use - Restrict driving if limited ROM - Perform stretching, core strengthening home regiment during PT
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SHOULDER PAIN, B-3

Anterolateral shoulder pain worsened by reaching overhead can be related to impingement syndrome, AC joint pathology, or rotator cuff injury. Posterior shoulder pain could be from rotator cuff injury, gallbladder, spleen, or neck.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Abnormal distal pulse or sensation in the setting of trauma is a medical emergency require immediate evaluation. Deformity can be a dislocated shoulder or fracture. Myocardial infarction can be associated with shoulder pain.

DP 1. The red flags indicate a medical emergency. Immobilize the affected extremity prior to transport if associated with trauma. Immediately refer shoulder pain associated with cardiac symptoms (sweating, shortness of breath, chest or jaw pain/ pressure). A red, warm, swollen joint or pain with fever can be a sign of an infected joint requiring immediate surgical evaluation. Abdominal symptoms suggest an extrinsic cause requiring evaluation.

DP2. Neurologic symptoms (numbness, weakness) suggest nerve impingement. Limited motion suggests a more significant injury that should be placed in a sling and require further evaluation. Laceration may require closure.

TREATMENT PROTOCOL, B-3

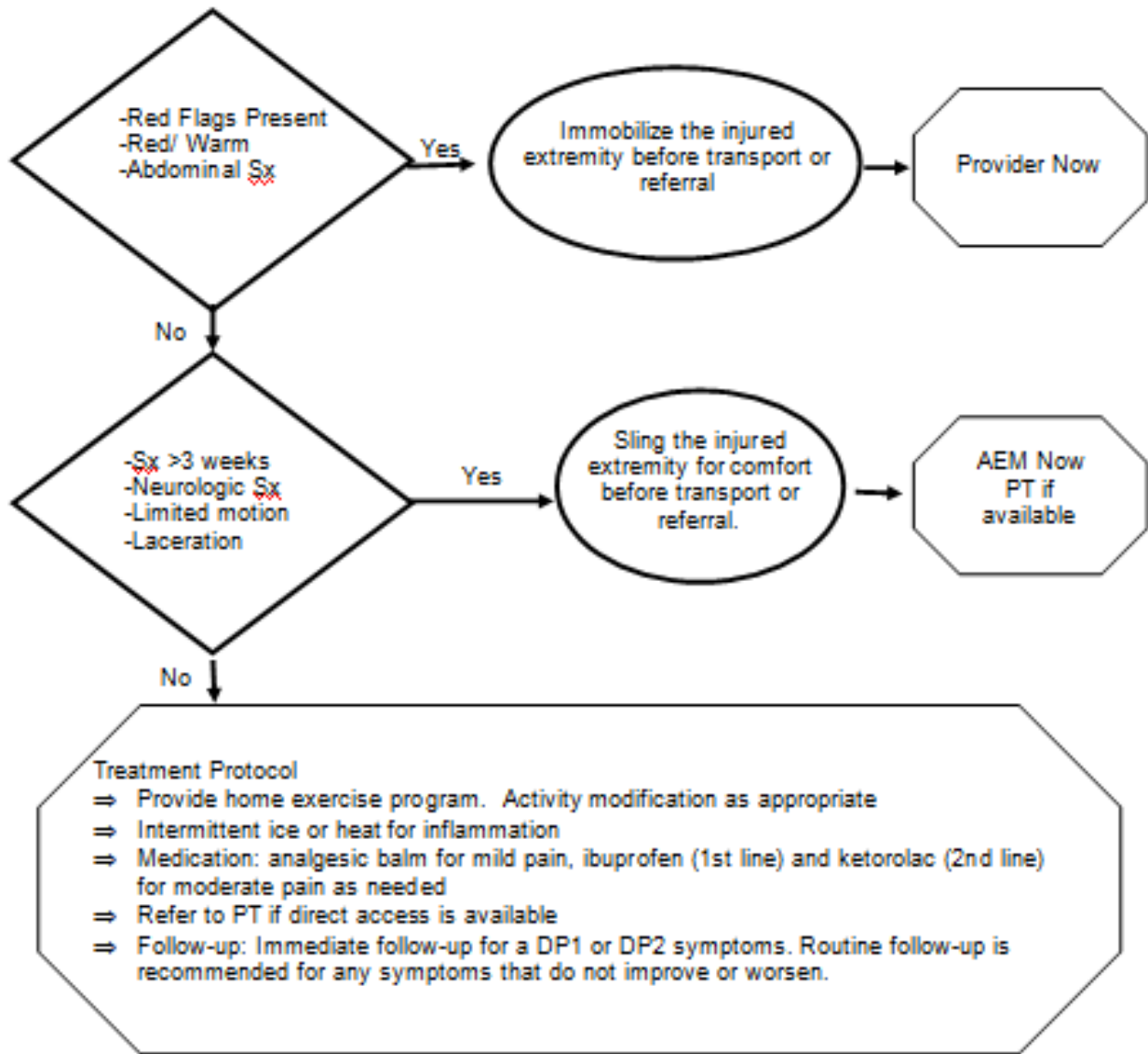
MCP. The best treatment is conservative measures including a home exercise program for mobilization and strengthening and analgesics as needed. A temporary profile may be required. Instruct the Soldier to work the injured shoulder through its range of motion (but not vigorous enough to cause pain) at least twice each day to preserve mobility after a 20-minute application of ice. Follow established local protocols for home exercise. Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Instruct the Soldier to seek medical assistance if pain becomes severe enough to prevent performance of normal duties/activities, worsening of other symptoms, symptoms last longer than one week.

Refer to PT if direct access to physical therapy (physical therapy sick call) is available, in accordance with local policy.

B-3: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-3: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Perform an Examination of the Shoulder	081-833-0269
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222

SHOULDER PAIN, B-3

Partial Differential Diagnosis Tendon inflammation/tear Instability (dislocation) Arthritis Fracture Myocardial Infarction	RED FLAGS - Distal Pulses Abnormal - Distal Sensation Abnormal - Deformity - Cardiac Symptoms	Activity Modification: - May lift, push, pull up to 5 lbs - No overhead lifting or repetitive activities - Perform stretching, core strengthening home regiment during PT
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ELBOW PAIN, B-4

Elbow joint is formed by the connection of the distal humerus and the proximal radius (radial head). Epicondyles are bony prominences on the medial and lateral side of the distal humerus and are the site tendon attachment for muscles of the lower arm. Lateral elbow pain may represent tennis elbow, radiohumeral joint pain, or referred pain.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Abnormal distal pulse or sensation in the setting of trauma is a medical emergency requiring immediate evaluation.

DP 1. Immobilize the affected extremity prior to transport if associated with trauma. A red, warm, swollen joint or pain with fever can be a sign of an infected joint requiring immediate surgical evaluation. Diffuse pain that involves multiple joints or muscles may represent a systemic cause and requires further evaluation.

DP2. Limited ROM and swelling may represent an issue within the joint requiring further evaluation. Neck and shoulder issues may refer pain to the elbow. Ulnar nerve pain may be referred to the ulnar side of the forearm, hand, pinky, and ring finger area.

TREATMENT PROTOCOL, B-4

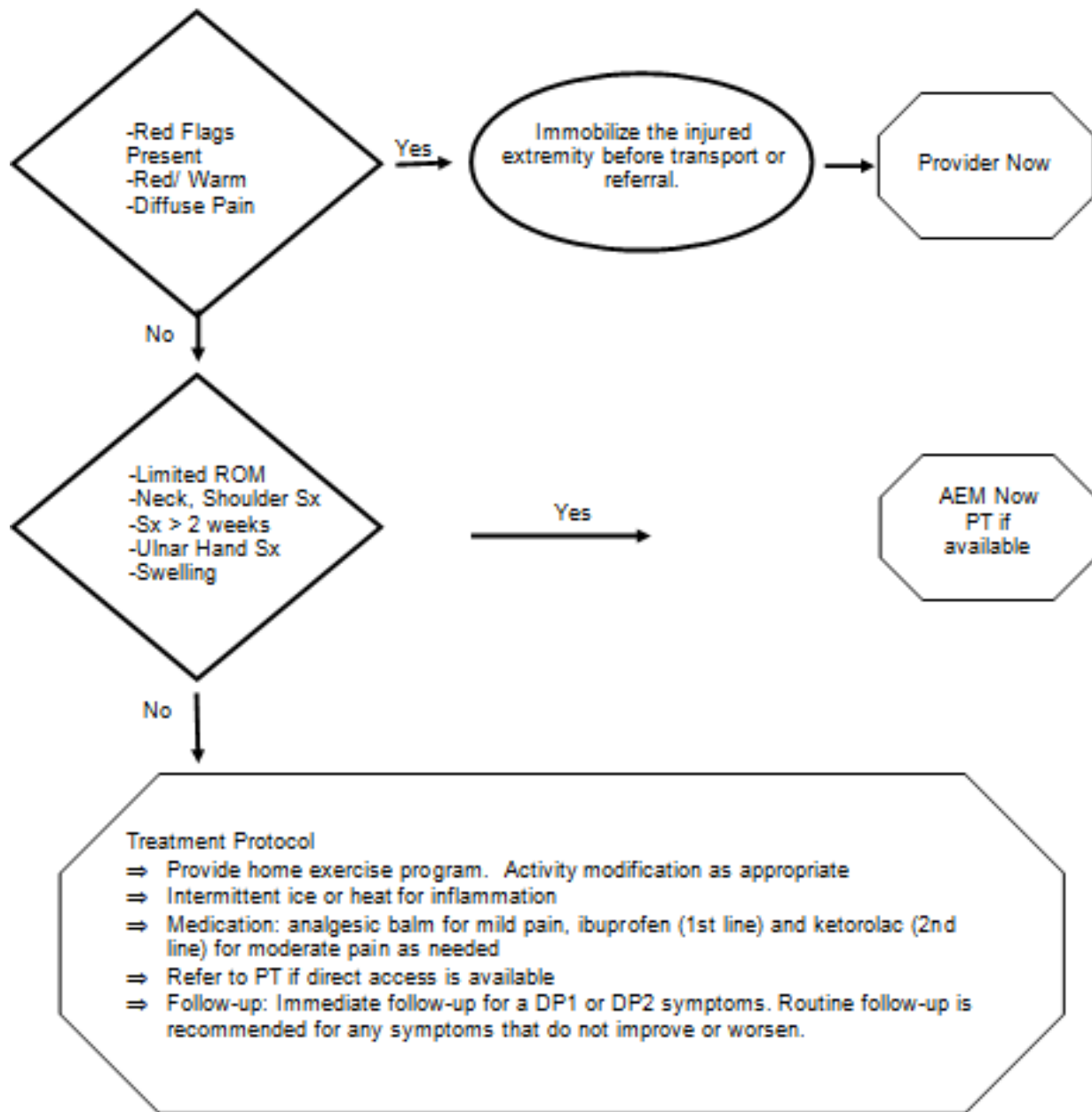
MCP. The best treatment is conservative measures including a home exercise program for mobilization and strengthening and analgesics as needed. A temporary profile may be required. Instruct the Soldier to work the injured elbow through its range of motion at least twice each day to preserve mobility. This should ideally be done after a 20-minute application of ice. The range of motion exercise should not be vigorous enough to cause pain. Follow established local protocols for home exercise. Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Instruct the Soldier to seek medical assistance if pain becomes severe enough to prevent performance of normal duties/activities, worsening of other symptoms, symptoms last longer than one week.

If direct access to physical therapy (physical therapy sick call) is available, consider direct referral to physical therapy in accordance with local policy.

B-4: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-4: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Perform an Examination of the Elbow	081-833-0270
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222

ELBOW PAIN, B-4

Partial Differential Diagnosis Muscle Strain Fracture Dislocation Tendonitis Bursitis	RED FLAGS - Distal Pulses Abnormal - Distal Sensation Abnormal - Deformity	Activity Modification: - May lift, push, pull up to 5 lbs - No repetitive bending of elbow or turning/ bending of wrist - Perform stretching, core strengthening home regiment during PT
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WRIST PAIN, B-5

Wrist pain usually occurs from trauma or overuse. Falling on an outstretched hand can result in a scaphoid (falling forward) or lunate/ triquetrum (falling back) injury. Ulnar side of wrist may involve tendinopathy, triangular fibrocartilage complex injury, or fracture. Radial side of wrist may involve tendinopathy, ligamentous injury, or fracture. Dorsal pain may involve a wrist sprain or fracture. Volar pain may involve fracture, ganglion, or carpal tunnel syndrome.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Abnormal distal pulse or sensation in the setting of trauma is a medical emergency requiring immediate evaluation.

DP 1. In the setting of trauma, the red flags are an indicator of a medical emergency. Immobilize the affected extremity prior to transport. A red, warm, swollen joint or pain with fever can be a sign of an infected joint requiring immediate surgical evaluation. Trauma and Pain without recent trauma or overuse injury may represent a systemic problem to include rheumatoid arthritis or Lyme disease.

DP2. Index finger or thumb numbness, pain, or weakness are symptoms of carpal tunnel syndrome. Clicking or popping with pain can be a sign of tendon instability. Ganglion is a mobile mass over a tendon that can be referred for drainage and treatment.

TREATMENT PROTOCOL, B-5

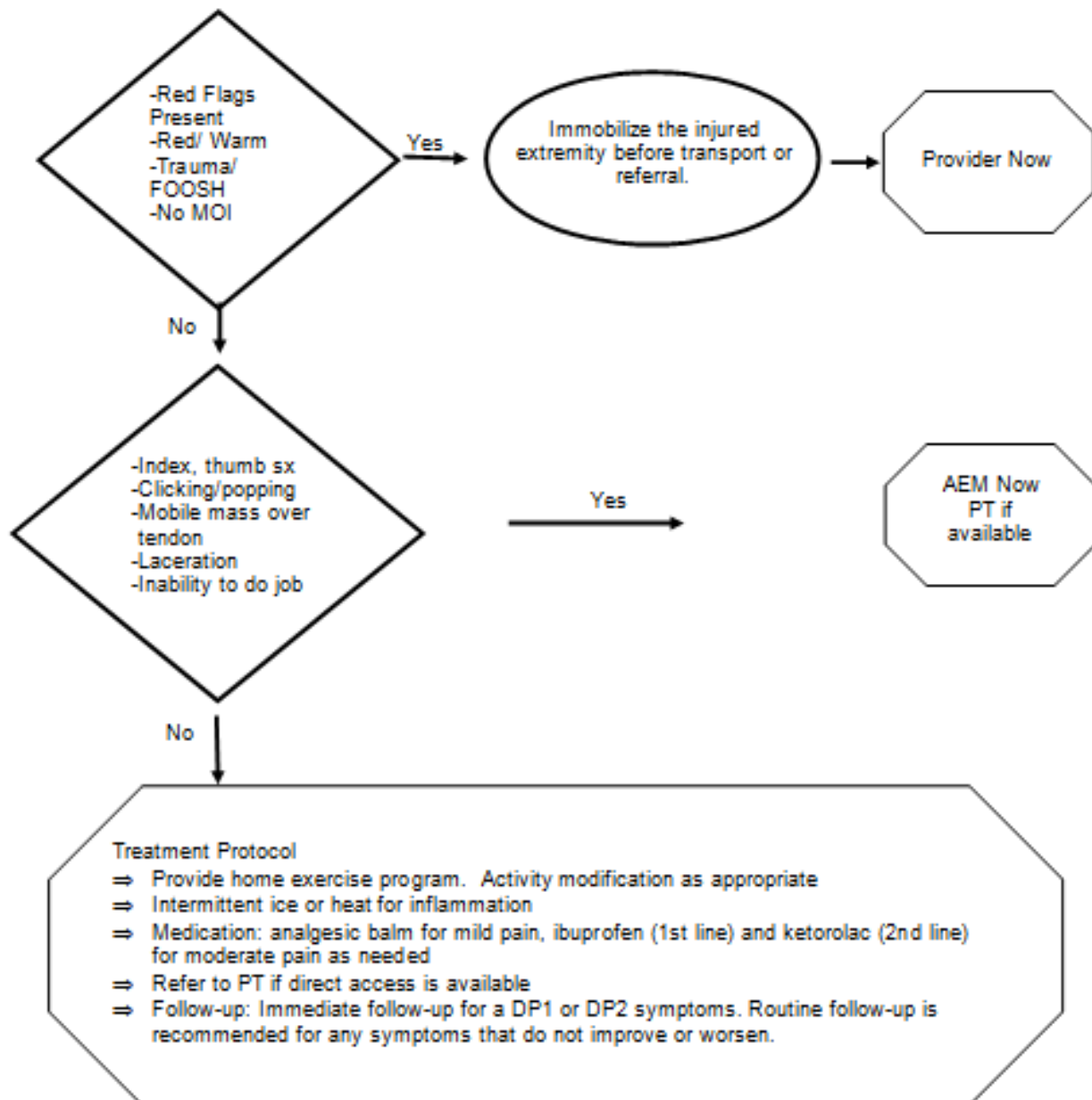
MCP. The best treatment is conservative measures including a home exercise program for mobilization and strengthening and analgesics as needed. Instruct the Soldier to work the injured wrist through its range of motion (but not vigorous enough to cause pain) at least twice each day to preserve mobility after a 20-minute application of ice. Follow established local protocols for home exercise. Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Instruct the Soldier to seek medical assistance if pain becomes severe enough to prevent performance of normal duties/activities, worsening of other symptoms, symptoms last longer than one week.

If direct access to physical therapy (physical therapy sick call) is available, consider direct referral to physical therapy in accordance with local policy.

B-5: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-5: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222
Subject Area 7: Musculoskeletal	Perform an Examination of the Wrist	081-833-0273

WRIST PAIN, B-5

Partial Differential Diagnosis Fracture Carpal Tunnel Arthritis Bursitis Tendonitis Muscle Strain	RED FLAGS - Distal Pulses Abnormal - Distal Sensation Abnormal - Deformity - Open Fracture	Activity Modification: - May Lift, push, pull up to 5 lbs - May wrap or wear a brace for comfort - No repetitive bending of wrist - Perform stretching, core strengthening home regiment during PT
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HAND PAIN, B-6

Any deviation of the hand from normal function can result in significant disability. Hand and finger injury are common in Soldiers.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Abnormal distal pulse or sensation in the setting of trauma is a medical emergency requiring immediate evaluation. Significant burns of the hands are considered high risk and should be evaluated for referral to a burn center.

DP 1. The red flags are an indication of a medical emergency. In the setting of trauma, immobilize the affected extremity prior to transport. Crush injuries and history of punching something are common causes of fractures requiring further evaluation.

DP2. Finger catching or locking during flexion may represent trigger finger. Ulcers can represent herpetic whitlow (herpes infection). Lacerations and abscesses require further evaluation.

TREATMENT PROTOCOL, B-6

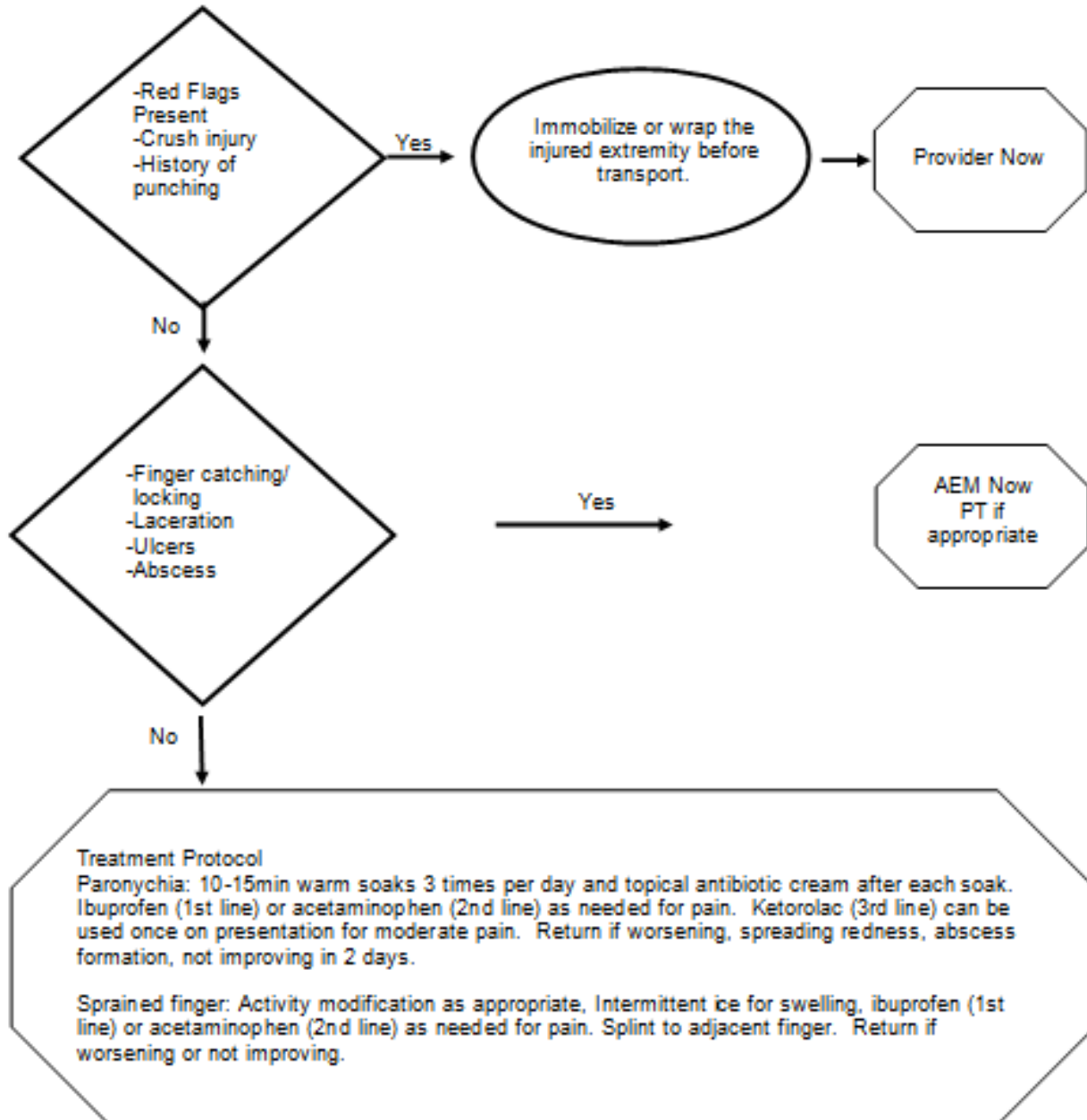
MCP for Paronychia: Instruct the Soldier to soak the finger in warm water for 10-15 minutes three times per day and apply topical antibiotic cream after each soak. Ibuprofen (1st line) or acetaminophen (2nd line) can be provided as needed for pain. Ketorolac (3rd line) can be used once on presentation if needed for moderate pain. Return if worsening, increasing redness, abscess formation, not improving in two days.

MCP for Sprained Finger: Anatomically splint the finger to the adjacent finger with tape. Instruct the Soldier on activity modification as appropriate. Instruct the Soldier on the intermittent use of ice for swelling, ibuprofen (1st line) or acetaminophen (2nd line) as needed for pain. Ketorolac (3rd line) can be used once on presentation if needed for moderate pain. Return to clinic if the symptoms are getting worse, pain becomes severe enough to prevent performance of normal duties/activities, or improvement is not seen within one week.

B-6: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-6: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222
Subject Area 7: Musculoskeletal	Apply a Rigid Splint	081-833-0263
Subject Area 7: Musculoskeletal	Apply an Elastic Bandage	081-833-0264

HAND PAIN, B-6

Partial Differential Diagnosis Fracture/ Dislocation Gout Carpal Tunnel Syndrome Arthritis Tendonitis Muscle Strain	RED FLAGS - Abnormal Capillary Refill - Abnormal Distal Sensation - Palmar Infection - Deformity - Significant Burn	Activity Modification: Paronychia - Keep area clean and dry Sprained Finger - May Lift, push, pull up to 5 lbs - May tape or brace comfort - No contact sports
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HIP PAIN, B-7

Lateral pain worse with direct pressure may represent trochanteric bursitis. Anterior hip or groin pain may represent the hip joint injury, fracture (stress fracture), or non-hip issue like inguinal hernia. Femoral stress fractures are more common in initial entry training. They can result in permanent disability if not properly identified and treated.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Abnormal distal pulse or sensation in the setting of trauma is a medical emergency requiring immediate evaluation.

DP1. Significant force of trauma to include car accident can cause a hip fracture. Immobilize the affected extremity prior to transport. Pain with weight bearing or starts after a certain point during exercise can be a sign of a stress injury. Increase in exercise, long endurance training, or recent modification to training can be risk factors of a stress injury. Place the Soldier on crutches with toe touch weight bearing until a bone stress injury is ruled out.

DP2. Lateral hip pain with paresthesia is the classic presentation for lateral femoral cutaneous nerve entrapment. Abdominal pathology, testicular pathology, inguinal hernia may present with anterior hip pain that is not worse with palpation, flexion, or weight bearing.

TREATMENT PROTOCOL, B-7

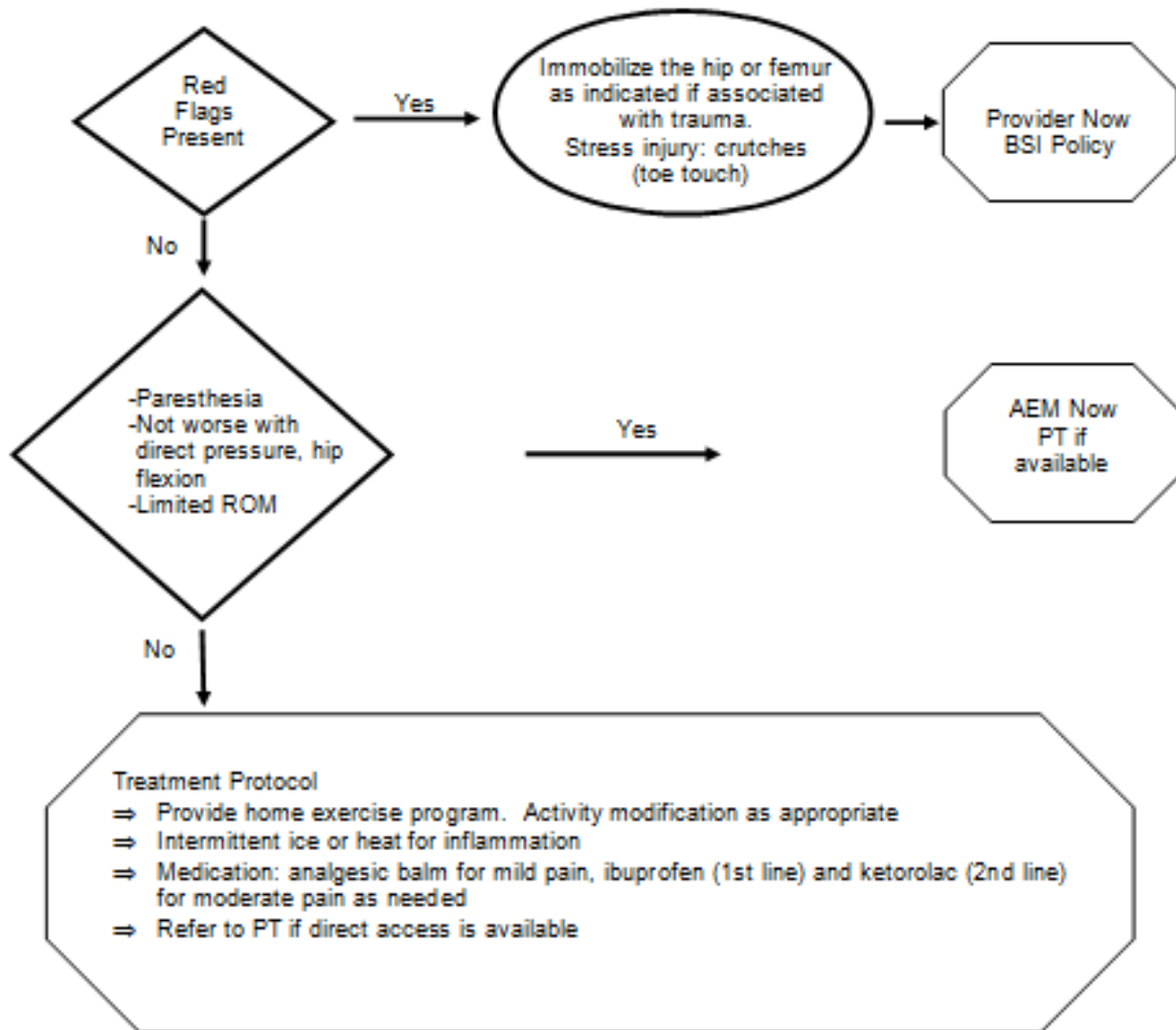
MCP for Hip Pain. The best treatment is conservative measures including a home exercise program for mobilization and strengthening and analgesics as needed. Instruct the Soldier to work the injured wrist through its range of motion (but not vigorous enough to cause pain) at least twice each day to preserve mobility after a 20-minute application of ice. Follow established local protocols for home exercise. Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Instruct the Soldier to seek medical assistance if pain becomes severe enough to prevent performance of normal duties/activities, pain with weight bearing or exercise develops, worsening of symptoms, symptoms last longer than 3 days.

If direct access to physical therapy (physical therapy sick call) is available, consider direct referral to physical therapy in accordance with local policy.

B-7: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-7: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Perform an Examination of the Hip	081-833-0274
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222
Subject Area 7: Musculoskeletal	Immobilize the Pelvis	081-833-0266

HIP PAIN, B-7

Partial Differential Diagnosis Arthritis Stress Fracture Trochanteric Bursitis Tendinitis Muscle Strain Hernia Referred Pain	RED FLAGS - Abnormal PMS - Deformity - High Energy Trauma - Suspect Stress Fracture (increased with weight bearing or during exercise, endurance training, change in exercise routine) - Severe Pain	Activity Modification: - No running, jumping but may walk up to ¼ mile at own pace/ distance and stand up to 20min - May Lift, carry, push, pull up to 25 lbs - No repetitive lifting from floor - Perform stretching, core strengthening home regiment during PT
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KNEE PAIN, B-8

Knee pain is a common complaint in Soldiers with a complex differential that includes evaluating for trauma, overuse, swelling, and referred pain.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.”

DP 1. In the setting of trauma, deformity with loss of peripheral pulses or sensation is an indication of a medical emergency. High energy trauma to include car accident, skiing injury, or fall from a height should be assumed to have a serious injury until ruled out. Immobilize the affected extremity prior to transport. Red, warm joint could represent inflammation or infection. Swelling immediately after a traumatic event can be a sign of bleeding into the knee joint. Closer the pain and swelling are related to the traumatic event, the more likely there is a significant injury. Lack of an identifiable cause or relation to activity suggests an inflammatory cause that requires further evaluation.

DP2. Swelling, decreased range of motion, and a previous knee injury increases the likelihood of a more significant injury like a knee injury reoccurrence or complication of the prior injury.

TREATMENT PROTOCOL, B-8

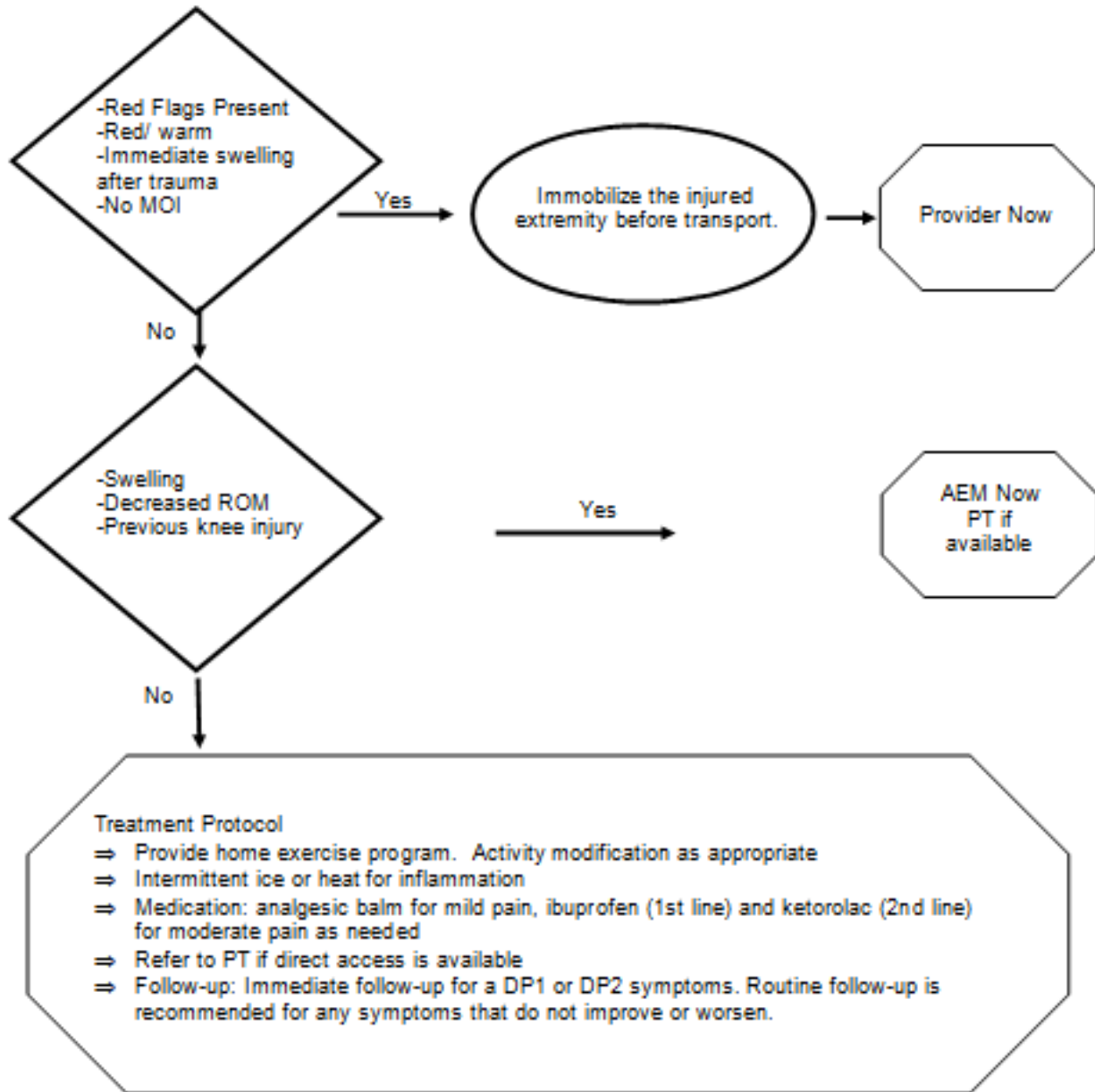
MCP for Knee Pain. The best treatment is conservative measures including a home exercise program for mobilization and strengthening and analgesics as needed. Instruct the Soldier to work the injured knee through its range of motion (but not vigorous enough to cause pain) three times a day to preserve mobility after a 20-minute application of ice. Follow established local protocols for home exercise. Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Instruct the Soldier to seek medical assistance if pain becomes severe enough to prevent performance of normal duties/activities, worsening of symptoms, knee catches/locks up or gives out, or symptoms last longer than a week.

If direct access to physical therapy (physical therapy sick call) is available, consider direct referral to physical therapy in accordance with local policy.

B-8: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-8: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Perform an Examination of the Knee	081-833-0268
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222
Subject Area 7: Musculoskeletal	Apply a Rigid Splint	081-833-0263
Subject Area 7: Musculoskeletal	Apply an Elastic Bandage	081-833-0264

KNEE PAIN, B-8

Partial Differential Diagnosis Ligament or Cartilage Injury Arthritis Overuse Injury Infection/Inflammation Bursitis	RED FLAGS - Abnormal PMS - Deformity - High Energy Trauma	Activity Modification: - No running, jumping but may walk up to ¼ mile at own pace/ distance and stand up to 15min - No repetitive squatting but may Lift, carry, push, pull up to 25 lbs - Perform stretching, core strengthening home regiment during PT - May wear a brace or wrap
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ANKLE PAIN, B-9

Ankle pain is a common complaint in Soldiers from overuse or trauma.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.”

DP 1. In the setting of trauma, deformity with loss of peripheral pulses or sensation is an indication of a medical emergency. Immobilize the affected extremity prior to transport. If posterior ankle pain, have the Soldier lie on his or her stomach and squeeze the calf. The test is positive if the foot does not plantar flex with squeezing the calf indicative of a possible Achilles tendon rupture. Pain unrelated to overuse or injury could be an inflammatory process requiring further evaluation.

DP 2. Ottawa rules are a way of screening for the likelihood of a fracture associated with an ankle sprain. Inability to bear weight after and take 4 steps, tenderness over the posterior tip of the medial or lateral malleolus, or tenderness at the proximal metatarsal are signs of a potential fracture. Squeeze test evaluates for syndesmotic sprain by compressing the fibula against the tibia at the mid-calf.

TREATMENT PROTOCOL, B-9

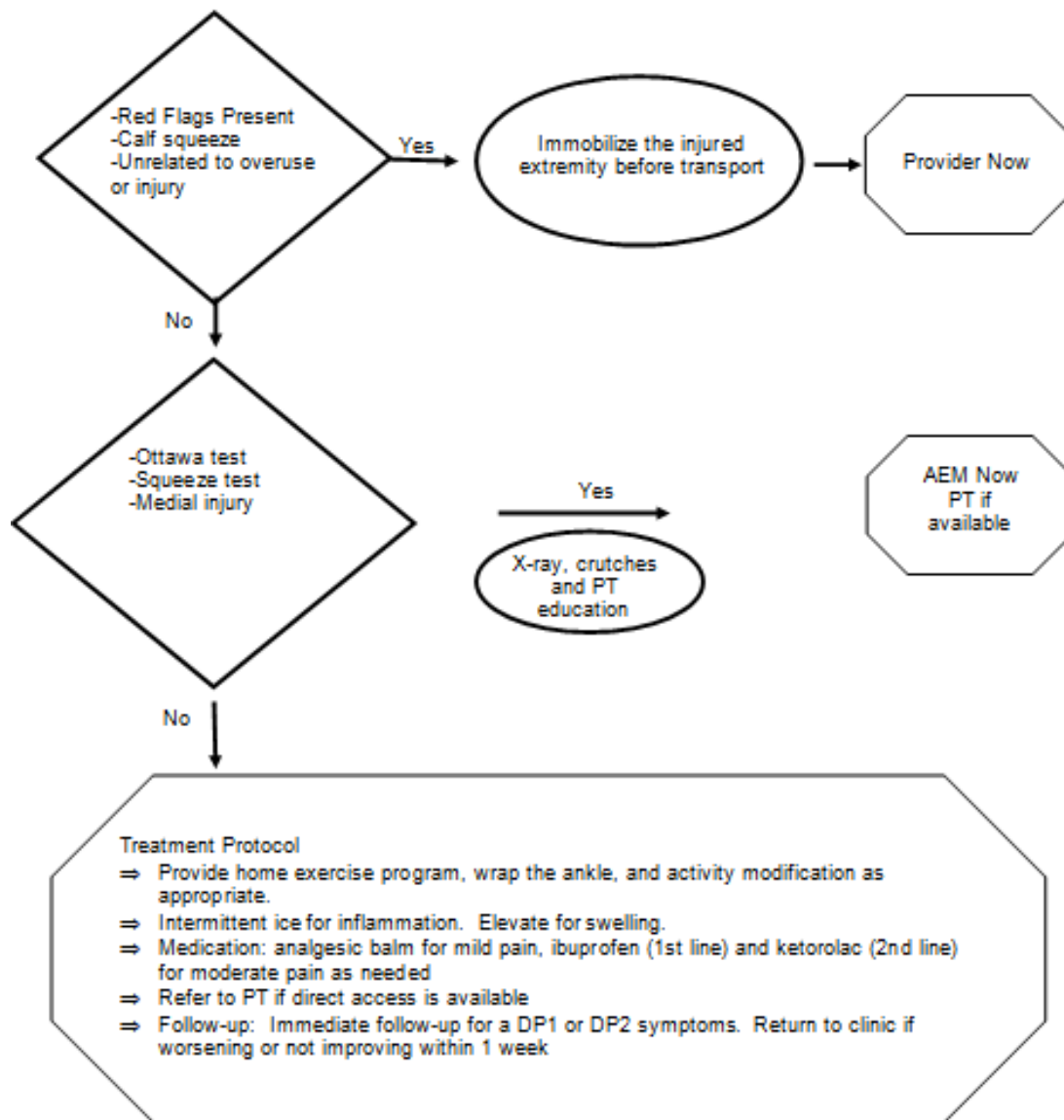
MCP for Ankle Pain. The best treatment is conservative measures including a home exercise program for mobilization and strengthening and analgesics as needed. Instruct the Soldier to work the injured ankle through its range of motion at least three times each day to increase mobility. This should ideally be done after a 20-minute application of ice. The range of motion exercise should not be vigorous enough to cause pain. Follow established local protocols for home exercise. Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Instruct the Soldier to seek medical assistance if pain becomes severe enough as to prevent performance of normal duties/activities, worsening, not improving within one week.

If direct access to physical therapy (physical therapy sick call) is available, consider direct referral to physical therapy in accordance with local policy.

B-9: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-9: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Perform an Examination of the Ankle	081-833-0272
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222
Subject Area 7: Musculoskeletal	Apply a Rigid Splint	081-833-0263
Subject Area 7: Musculoskeletal	Apply an Elastic Bandage	081-833-0264

ANKLE PAIN, B-9

Partial Differential Diagnosis Sprain/Strain Fracture Tendon Rupture Arthritis Bursitis Tendinopathy	RED FLAGS - Abnormal Distal Pulse - Abnormal Sensation - Deformity	Activity Modification: - No running, jumping, rucking but may walk up to ¼ mile at own pace/distance and stand up to 20min - May Lift, carry, up to 25 lbs - Limit walking over uneven terrain - Perform stretching, strengthening home regiment during PT - May wear brace or wrap
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FOOT PAIN, B-10

Common anterior foot pains include around the big toe (bunion, sprain, arthritis, sesamoiditis, ingrown toenail, subungual hematoma) and below the 2nd and 3rd metatarsals (metatarsalgia, Morton's neuroma, and plantar wart).

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as "Provider Now."

DP 1. In the setting of trauma, deformity with loss of peripheral pulses or sensation is an indication of a medical emergency. Immobilize the affected extremity prior to transport. Constant pain can be a sign of a more serious injury. Unrelated to overuse or injury can be a sign of inflammation requiring further evaluation.

DP 2. Numbness is often a sign of nerve compression. Refer to PT if direct access is available. Red, warm, and abscess can be signs of infection requiring further evaluation and treatment.

TREATMENT PROTOCOL, B-10

MCP for ingrown toenail. Soak in antibacterial soap and water for 20min three times per day. Place cotton under the nail to push it way from the affected lateral nail fold. Consult the supervising privileged provider for toenail removal evaluation (J-18) if moderate to severe.

MCP for subungual hematoma. After discussion and concurrence by supervisor, treat by puncturing the nail allowing for trapped blood and pressure to be relieved. Keep the affected toe clean. Soak it in antibacterial soap and water twice a day for 3 days.

MCP for plantar fasciitis or foot pain. Home exercise program (stretch, strengthen) and icing of the affected arch. Arch support may assist in preventing recurrence.

MCP for blisters, callus (see J-15). Use moleskin and activity modification.

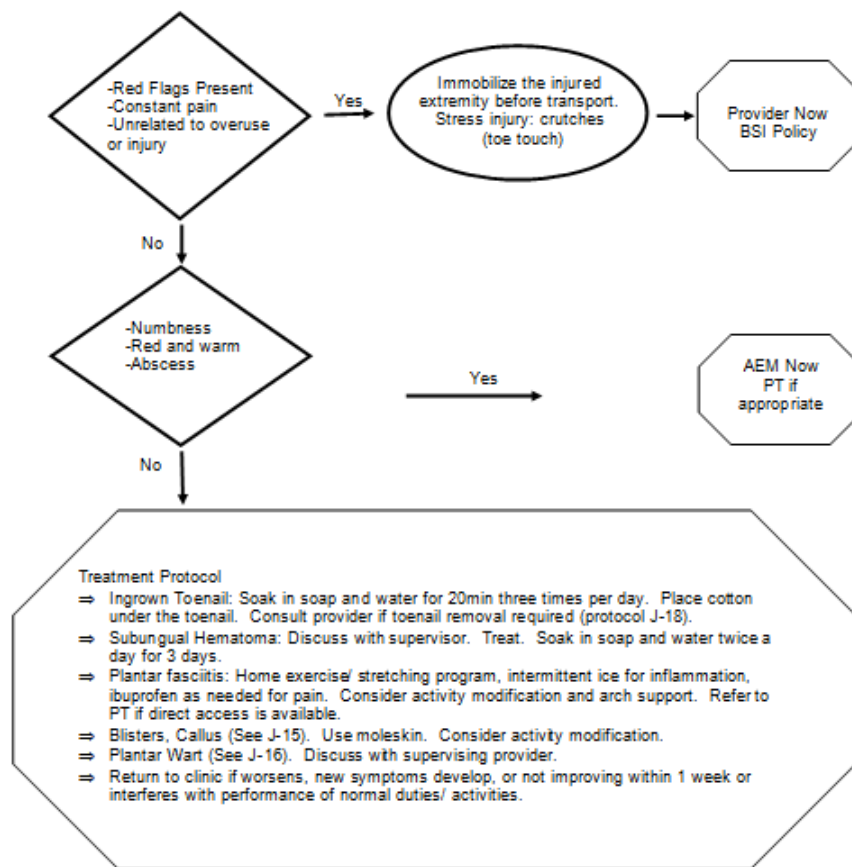
MCP for plantar wart (see J-16). Discuss with your supervising NCO.

All MCPs for feet Issues. Medication: ibuprofen (1st line) and ketorolac (2nd line) for moderate pain as needed. Instruct the Soldier to seek medical assistance if symptoms worsen, pain becomes severe enough as to prevent performance of normal duties/activities, not improving within one week of minor-care.

B-10: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-10: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222
Subject Area 7: Musculoskeletal	Apply a Rigid Splint	081-833-0263
Subject Area 7: Musculoskeletal	Apply and Elastic Bandage	081-833-0264

FOOT PAIN, B-10

Partial Differential Diagnosis Injury Overuse Plantar Fasciitis Tarsal Tunnel Syndrome Achilles Tendinopathy Ingrown Toenail Bunion	RED FLAGS - Abnormal Distal Pulse - Abnormal Sensation - Deformity - Suspect Stress Fracture (increased with weight bearing or during exercise, endurance training, change in exercise routine)	Activity Modification: - No running, jumping, rucking but may walk up to ¼ mile at own pace/ distance and stand up to 20min - May Lift, carry, up to 25 lbs - Perform stretching, strengthening home regiment during PT
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EXTREMITY, NON-JOINT PAIN, B-11

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.”

DP 1. In the setting of trauma, deformity with loss of peripheral pulses or sensation is an indication of a medical emergency. Immobilize the affected extremity prior to transport. Cola colored urine or inability to urinate after exercise can be a sign of rhabdomyolysis. Bolus 1 liter of normal saline to help flush the myoglobin out of the kidneys. Severe pain can be a sign of compartment syndrome and may require emergent surgical decompression. Pain with weight bearing or starts after a certain point during exercise can be a sign of a stress injury. Increase in exercise, long endurance training, or recent modification to training can be risk factors of a stress injury. Place the Soldier on crutches until a bone stress injury is ruled out. Swelling or erythema can be signs of an infection or a venous blood clot.

DP 2. Limited motion or loss of strength can be a sign of a muscle tear or rupture. Laceration needs to be evaluated for possible closure.

Treatment Protocol, B-11

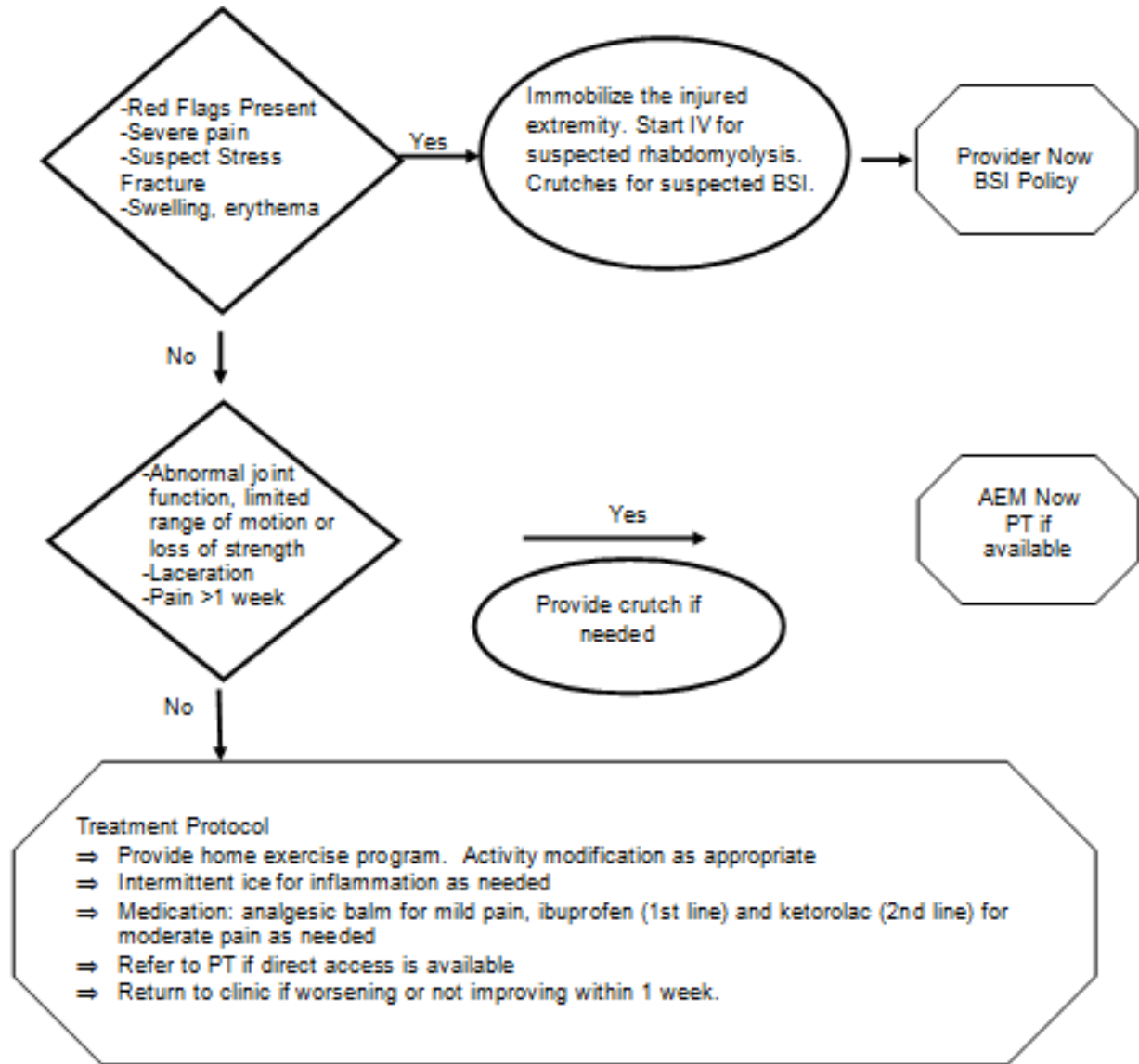
MCP for overuse injuries. Exercise modification should be done to limit the use of the area that is involved. Instruct the Soldier to stretch the injured area for at least a minute 4 times per day. Home exercise program can be used to strengthen the area. Follow established local protocols for home exercise. Intermittent ice and heat can be used for inflammation. Medication: analgesic balm for mild pain, ibuprofen (1st line) and ketorolac (2nd line) for moderate pain. Instruct the Soldier to seek medical assistance if pain becomes so severe as to prevent performance of normal duties/activities, worsening, development of significant swelling or skin color change, soreness in uninjured areas, or not improving within one week.

If direct access to physical therapy (physical therapy sick call) is available, consider direct referral to physical therapy in accordance with local policy.

B-11: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
B-11: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 7: Musculoskeletal	Treat Common Musculoskeletal Disorders	081-833-0222
Subject Area 7: Musculoskeletal	Apply a Rigid Splint	081-833-0263
Subject Area 7: Musculoskeletal	Apply and Elastic Bandage	081-833-0264

EXTREMITY, NON-JOINT PAIN, B-11

Partial Differential Diagnosis Fracture Laceration Bruise Stress Reaction	RED FLAGS - Abnormal Distal Pulse - Abnormal Sensation - Deformity - Cola Colored Urine - Inability to Urinate	Activity Modification: Use the activity limitations for the joint in the protocols above that is closest to the area.
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NAUSEA/VOMITING, C-1

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Vomiting blood/coffee grinds and melena can be signs of an intestinal bleed. Neurologic symptoms can be a sign of increased intracranial pressure. Myocardial infarction can present with nausea.

DP 1. These represent the possibility of more significant underlying medical conditions. A common side effect of chemotherapy treatment is nausea and vomiting that is sometimes difficult to control. BMI less than 18 can be a sign of an eating disorder like bulimia or another significant medical condition. Uncontrolled diabetes and gastroparesis due to diabetes can also present with nausea and vomiting.

DP 2. These are symptoms that are related to volume depletion. Fluid depletion is a risk of significant nausea and vomiting. If a Soldier is not able to maintain fluid intake due to his or her nausea and vomiting, then short term hospitalization has to be considered until the nausea and vomiting can be controlled. Nausea and vomiting, especially in the mornings, is a common symptom in pregnancy. If a Soldier has a positive pregnancy test or symptoms of nausea during pregnancy, she will require a longer-term plan than the minor-care protocol can accommodate.

DP 3. There are many other symptoms that can be associated with nausea and vomiting to include dizziness (vertigo), headaches (migraines) and heartburn. Reflux and regurgitation (return of gastric contents to hypopharynx with little effort) can be seen with heartburn and do not require treatment unless symptomatic.

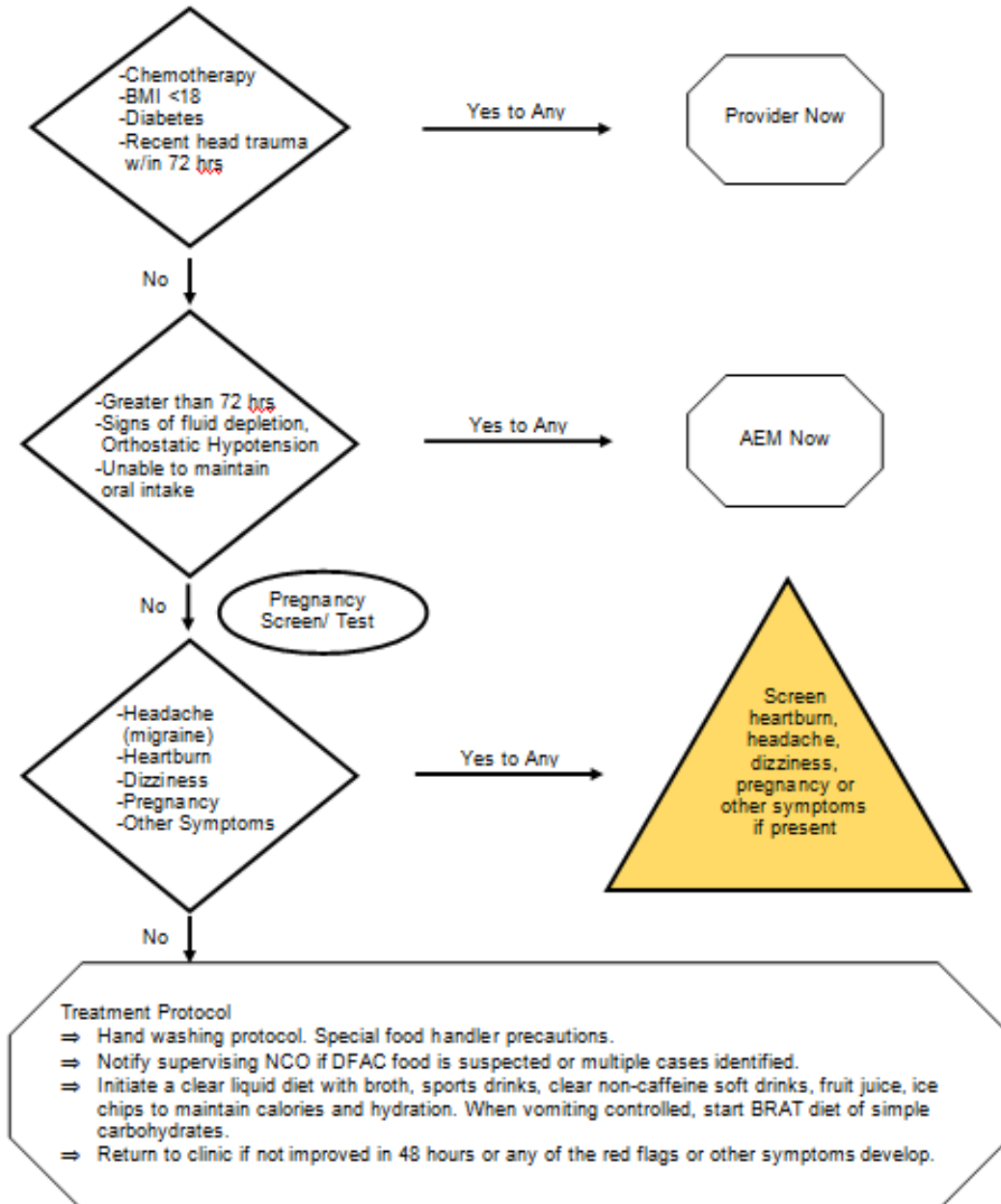
TREATMENT PROTOCOL, C-1

MCP for nausea/vomiting. Handwashing is important to prevent spread of disease. Due to contagion risk, activity modification is important for food handlers and multiple cases or when DFAC food is suspected must be reported to the supervising NCO due to the potential of an outbreak. Diet control is very important in treating nausea and vomiting. Ice chips should be used initially. Once vomiting is controlled, advance to clear liquids (broth, fruit juice, sports drink and caffeine free soda). Start with small sips and slowly advance. Once the Soldier has been able to tolerate liquids for 24 hours, advance to a BRAT (bread, rice, apple sauce, toast) diet of simple carbohydrates. The Soldier with severe or persistent vomiting that is unable to tolerate liquids will require IV fluids. Advise the Soldier to return for medical assistance if the symptoms last more than two days, if blood appears in his vomit or in his stools, or if he becomes dizzy and/or faints upon standing. Vomiting that is severe enough to prevent the Soldier from keeping clear liquids down for 24 hours, severe abdominal pain, or worsening symptoms are also causes for a prompt return visit.

C-1: In accordance with MEDCOM Regulation 40-50		
Administer Antiemetic	pg. 67	(3)(g)
Obtain Laboratory Specimens	pg. 69-70	(2)(k)

NAUSEA/VOMITING, C-1

Partial Differential Diagnosis Medication Infection Intense Pain Pregnancy Concussion Heartburn	RED FLAGS - Vomiting Blood or Coffee Grinds, Melena - Neurologic Symptoms - Chest Pain - Abdominal Pain followed by Nausea - Abdominal Distension	Activity Modification: - No food handling, if work in a DFAC, until symptoms have resolved x 48 hours
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DIARRHEA, C-2

Acute diarrhea in adults are often infectious in nature. The largest risk is due to volume depletion secondary to fluid loss. Small intestine infections often results in large, watery bowel movements associated with cramping, bloating, and gas symptoms. Large intestine infections often results in frequent regular, small bowel movements that are painful and associated with symptoms of mucous, blood, or fever. In general, diarrhea is often self-limited. Note that treatment of the symptoms by decreasing bowel movements frequency may extend the length of the disease.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Nausea/ vomiting blood or coffee grinds and melena can be signs of an intestinal bleeding. Melena is a tar like stool with a very pungent odor resulting from the digestion of blood.

DP 1. Recent hospitalization and antibiotic use are risk factors for a clostridium difficile infection. Clostridium difficile infections often present with a strong odor and bloody diarrhea and can result in life threatening infections. Bloody diarrhea that is not just on the toilet paper from repetitive irritation or from a gastrointestinal bleed is likely the result of an invasive infection. Visibly bloody diarrhea could also be from inflammatory bowel disease or ischemic colitis. Severe abdominal pain as Soldier appearing in discomfort/distress including moaning, crying, bending over, trouble moving or pain rating of 8+/10.

DP 2. Severe or persistent symptoms may require the use of empiric antibiotics.

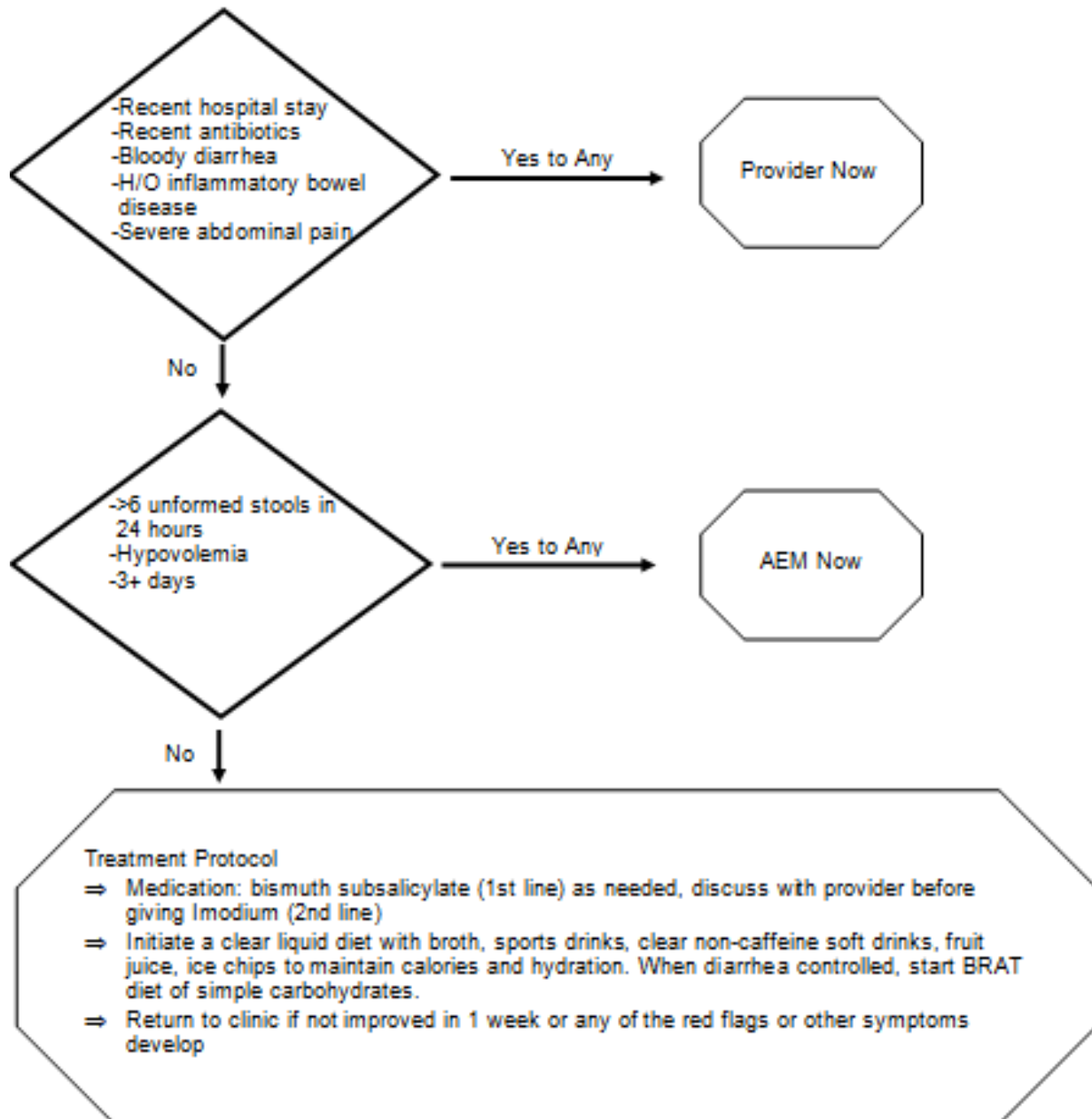
TREATMENT PROTOCOL, C-2

MCP for Diarrhea. Start a clear liquid diet (broth, fruit juice, sports drink, caffeine free soda) for 24 hours. Advance to a BRAT (banana, rice, apple sauce, toast) diet of simple carbohydrates next. Watch for signs of dehydration. Pepto-Bismol (1st line) may be given to the Soldier for the symptomatic control of diarrhea. Discuss with the supervising provider if antibiotics are required when considering to use Imodium (2nd line). Frequent hand washing should be used after using the bathroom and before eating. Food workers must not handle food till after symptoms have resolved. Advise the Soldier to return for medical assistance if the symptoms last more than one week, if symptoms worsen, or if he becomes dizzy and/or faints upon standing.

C-2: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg. 69-70	(2)(k)
C-2: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 2: Medical Treatment	Initiate Treatment for a Poisoned Casualty	081-833-0004
Subject Area 6: Primary Care	Provide Treatment for Abdominal Disorders	081-833-0239
Subject Area 16: CBRN	Provide Treatment for a Radiation Casualty	081-833-0280

DIARRHEA, C-2

Partial Differential Diagnosis Food Intolerance Medication Infection (Viral/Bacterial) Dizziness Chest Pain Ear Pain Heartburn	RED FLAGS Vomiting Blood or Coffee Grinds, Melena - Severe abdominal pain - Significant weight loss	Activity Modification: - No food handling, if work in a DFAC, until symptoms have resolved x 48 hours - Must have access to a restroom within 2 minutes
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ABDOMINAL AND FLANK PAIN, C-3

Abdominal pain is pain between the ribs and groin in the front half of the body. Note that a cardiac problem can cause upper abdominal pain. Pain may be related to the location: right upper quadrant (RUQ) (liver, gallbladder), left upper quadrant (LUQ) (spleen), epigastric (stomach, pancreas, aorta, heart), lower (intestines, urinary tract, hernia, pelvic organs), flank (kidney).

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Unstable vitals represent a significant health risk. Abdominal rigidity and rebound or significant Soldier discomfort with bumping the Soldier’s stretcher/chair are signs of peritonitis and can represent a surgical abdomen. Level of pain may represent the significance of the underlying disease.

DP 1. Suspected melena and coffee grind emesis should be tested and referred to a privileged provider if positive.

DP 2. Periumbilical pain that moves to the right lower quadrant (RLQ) is a sign of appendicitis. Pancreatitis and appendicitis are often associated with a loss of appetite. Women of childbearing age should have their pregnancy status verified. Abdominal pain in the setting of pregnancy or recent abdominal trauma can signify an underlying issue. Chronic abdominal pain requires further evaluation by a qualified provider. New-onset benign, functional illness in a Soldier 50 plus years old is unlikely and should be evaluated further.

DP 3. Abdominal pain frequently accompanies nausea, diarrhea, and constipation. Soldiers should be screened for the complaint. Pelvic pain has an additional partial differential diagnosis and should be screened according to that protocol. Urinary symptoms can progress from a urinary tract infection to a bladder infection causing flank pain.

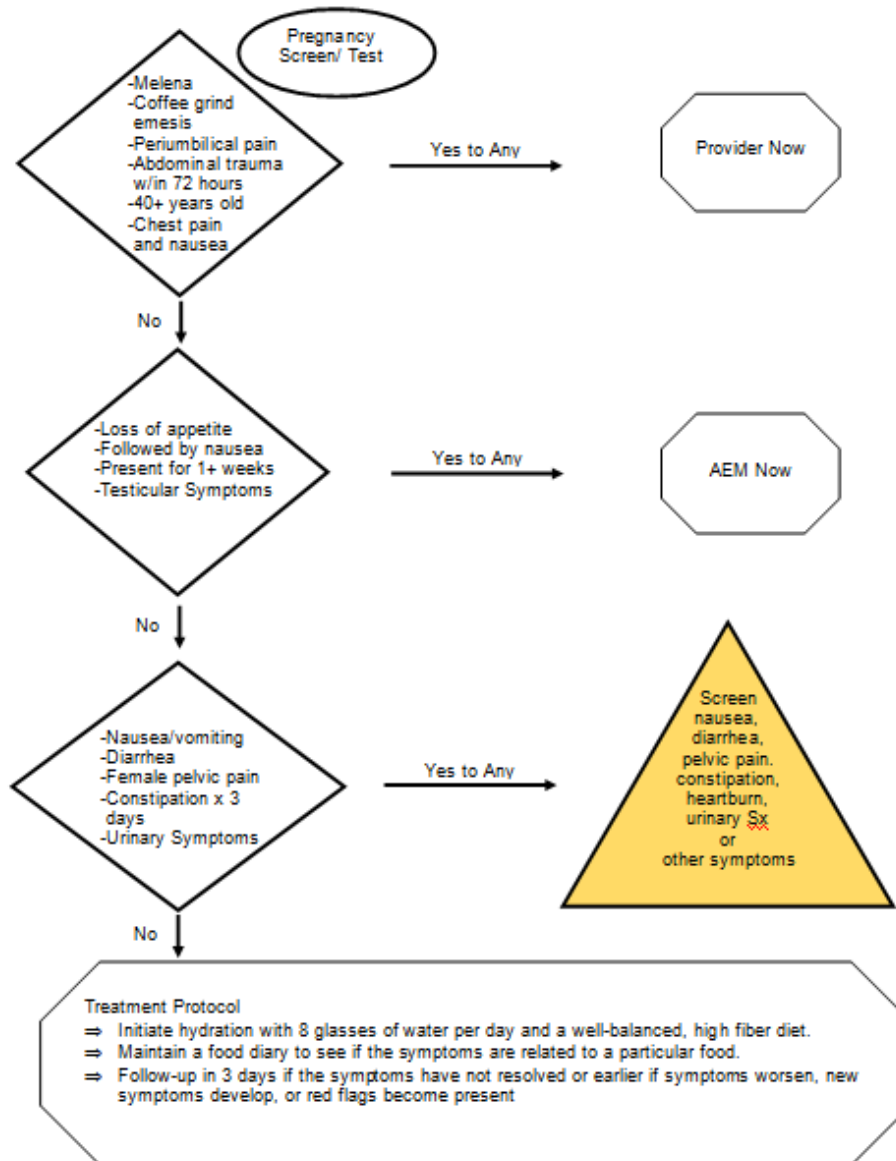
TREATMENT PROTOCOL, C-3

MCP for Abdominal Pain. After significant underlying diseases have been ruled out, many causes of abdominal pain are not identified in the acute setting. Gas pain, constipation, stress are some of the potential other causes of the pain. The pain usually resolves on its own. Initial treatment includes hydration and a well-balanced, high fiber diet to help with any potential issues with constipation. A food diary looks for potential triggers. Follow-up if symptoms worsen, red flags, new symptoms, or no improvement in three days.

C-3: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg. 69-70	(2)(k)
C-3: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Provide Treatment for Abdominal Disorders	081-833-0239

ABDOMINAL AND FLANK PAIN, C-3

Partial Differential Diagnosis MI, AAA Appendicitis Pancreatitis, Hepatitis Heartburn Ectopic Pregnancy Testicular Torsion Pelvic Inflammatory Dis.	RED FLAGS - Abnormal Vitals - Abdominal rigidity/rebound (bump chair) - Severe pain - Fever with jaundice and RUQ pain - Confirmed Pregnancy - Alcoholism - Immunocompromised - RLQ Pain	Activity Modification: - No running, jumping, riding in vehicle over uneven terrain - Aerobic activity at own pace/ distance - Abdominal training at own intensity/ rep
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RECTAL PAIN/ITCHING/BLEEDING, C-4

Rectal pain, itching, and bleeding are often signs of hemorrhoids or an anal fissure but more serious conditions must be ruled out.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of hemodynamically significant stomach/ intestinal bleeding.

DP 1. Feeling lightheaded and orthostatic hypotension can be signs of significant blood loss. Hemoccult stool test can identify blood in the stool. Blood only on the outside of the stool or toilet paper is more likely to be from a hemorrhoid or anal fissure. If a stool sample cannot be obtained except by a rectal exam, then refer as “Provider Now” for the rectal exam. If a hemoccult stool test is not available, then Soldiers with blood on the outside of the stool or on the toilet paper only should be considered as negative. Blood mixed in with the stool should be treated as positive. If you are unsure, consider it positive.

DP 2. These are symptoms of more concerning disease processes to include cancer with a family history of colon cancer before 45 years old, inflammatory bowel disease, and invasive gastroenteritis.

TREATMENT PROTOCOL, C-4

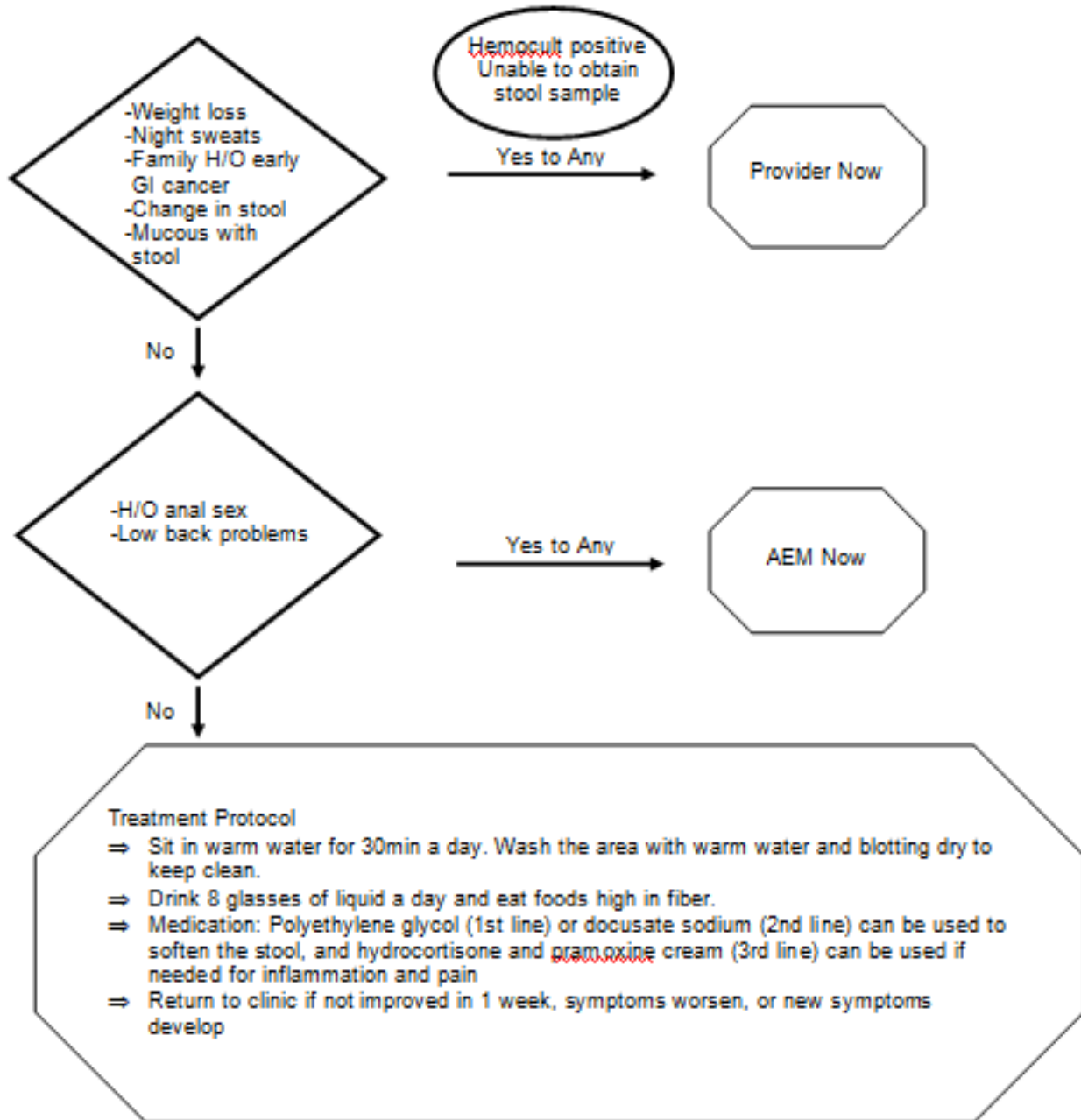
Hemorrhoids are enlarged veins around the rectum that protrude; get rubbed; and/or become painful from inflammation related to a small clot forming within the vein. Hemorrhoids are not dangerous but can be extremely uncomfortable. A Soldier who has a history of hemorrhoids or anal fissure and then develops similar symptoms likely has a recurrence. Soldier should be instructed on avoiding constipation since it is a common cause of hemorrhoids and anal fissures. Most people with itching (and no other symptoms) do not have a serious disease.

MCP for hemorrhoids and anal fissures. To decrease the amount of irritation, the stool needs to be soft. Advise the Soldier to ensure adequate intake of fluids (8 glasses a day), eat foods high in fiber like bran cereal and fresh fruits and vegetables, and spend less than five minutes on the toilet at a time. Increase fiber slowly as too much fiber at once may cause stomach cramping and gas. Tell the Soldier that the area should be kept clean by washing with warm water and blotting (rather than wiping) dry. Sitting in warm water can improve healing. Polyethylene glycol (1st line) or docusate sodium (2nd line) can be used to help keep the stool soft. Hydrocortisone and pramoxine cream (3rd line) can be used if needed for inflammation and pain. Instruct the Soldier in its use and to return for evaluation if the symptoms worsen, new symptoms develop, or symptoms last longer than one week or recurs.

C-4: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Provide Treatment for Abdominal Disorders	081-833-0239
Subject Area 15: Primary Care	Test a Stool Sample	081-833-0256

RECTAL PAIN/ITCHING/BLEEDING, C-4

Partial Differential Diagnosis Gastrointestinal Bleed Cancer Infection IBD Hemorrhoid/Fissure	RED FLAGS - Toilette FULL of Blood - Vomiting Blood or Coffee Grinds - Melena - Lightheaded	Activity Modification: None
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CONSTIPATION, C-5

Constipation means infrequent or difficult bowel movements. Soldiers use the word to mean many things—painful defecation, narrowing of the stools, or not having a “regular daily” bowel movement. Normal bowel habits differ from Soldier to Soldier; therefore, a wide variation exists in what Soldiers consider to be normal or to be a problem.

Because constipation and hemorrhoids commonly occur together, rectal bleeding may be falsely attributed to these causes. This can be a dangerous mistake. Rectal bleeding must be screened as a separate problem. Constipation not associated with rectal bleeding may be appropriately treated through minor-care.

DP 1. These are symptoms of hypothyroidism. Soldiers that screen positive for possible hypothyroidism should be referred for further evaluation.

DP 2. Rectal bleeding can be a sign of significant internal bleeding that requires further evaluation.

TREATMENT PROTOCOL, C-5

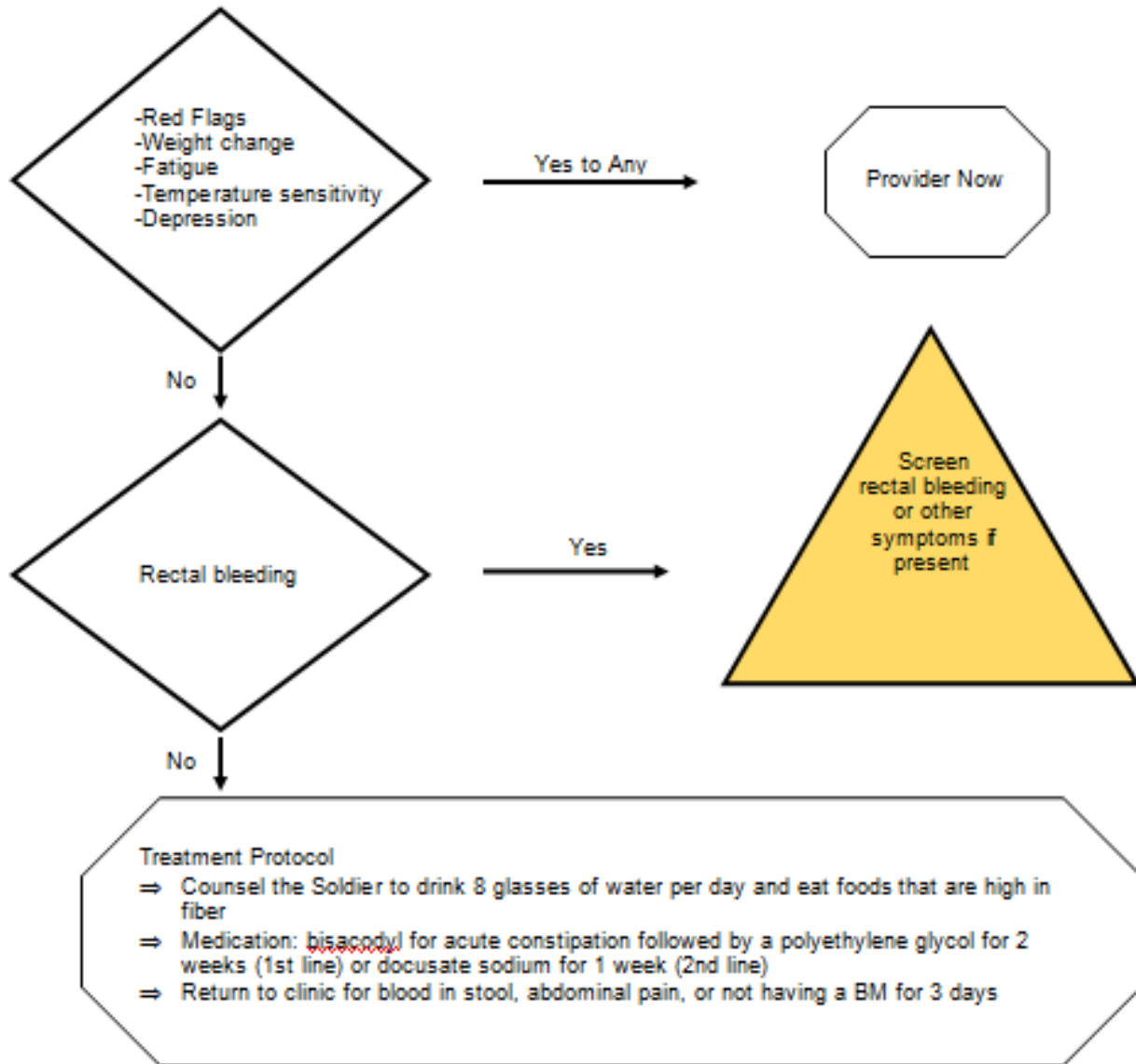
The most important step in treating constipation is to alter the diet so that it contains plenty of fiber. Fiber is that part of food which is not absorbed into the body but instead remains in the intestines and absorbs water to form the bulk of the bowel movements. Without proper bulk, the large and small intestines cannot work properly, and this causes constipation. Fiber is present in bran cereal, whole wheat bread, fresh fruits, and vegetables. Ensure that the Soldier is taking adequate water (8 glasses a day).

Laxatives can be used on a one-time basis but should not be used repeatedly because the body can become dependent on them. After the bisacodyl, use polyethylene glycol for two weeks (1st line) or docusate sodium for one week (2nd line) to prevent recurrence. Not everyone has a bowel movement every day. Bowel movements may occur as often as three times a day or once every three days and still be normal. Discomfort and a change in pattern are more reliable guides to a diagnosis of constipation. Instruct the Soldier to return for medical assistance if abdominal pain develops, if the interval between movements is three days or longer, or if blood appears in his or her stool.

C-5: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Provide Treatment for Abdominal Disorders	081-833-0239

CONSTIPATION, C-5

Partial Differential Diagnosis Obstruction Cancer Hypothyroidism Constipation Associated with Hemorrhoids	RED FLAGS - Diarrhea at night - Iron deficiency anemia - Vomiting	Activity Modification: None
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DIFFICULTY WHEN SWALLOWING (DYSPHAGIA), C-6

Dysphagia means difficulty or pain when swallowing.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” Airway compromise is an emergency. Coughing, choking, or nasal regurgitation when initiating a swallow is a sign of decreased ability to maintain the airway. The Soldier is at risk for aspiration.

DP 1. Most common cause of dysphagia in an adult is an acute food obstruction. It is often due to swallowing a piece of meat that has not been fully chewed. Food obstruction will present with a feeling of something stuck in the throat and decreased or inability to swallow. The obstruction must be removed promptly. Complete obstruction should undergo an emergent endoscopy. A partial obstruction should undergo endoscopy within 24 hours. The esophagus can start to ulcerate and the risk of esophageal perforation increases after 24 hours. If endoscopic evaluation/ treatment is not available within 24 hours, see the treatment protocol below.

DP 2. Other causes of dysphagia not related to a sore throat should be evaluated by the AEM.

DP 3. Dysphagia frequently accompanies a severe sore throat. However, MAKE CERTAIN that dysphagia did not precede the sore throat. Causes of dysphagia not associated with a sore throat may require a more extensive evaluation.

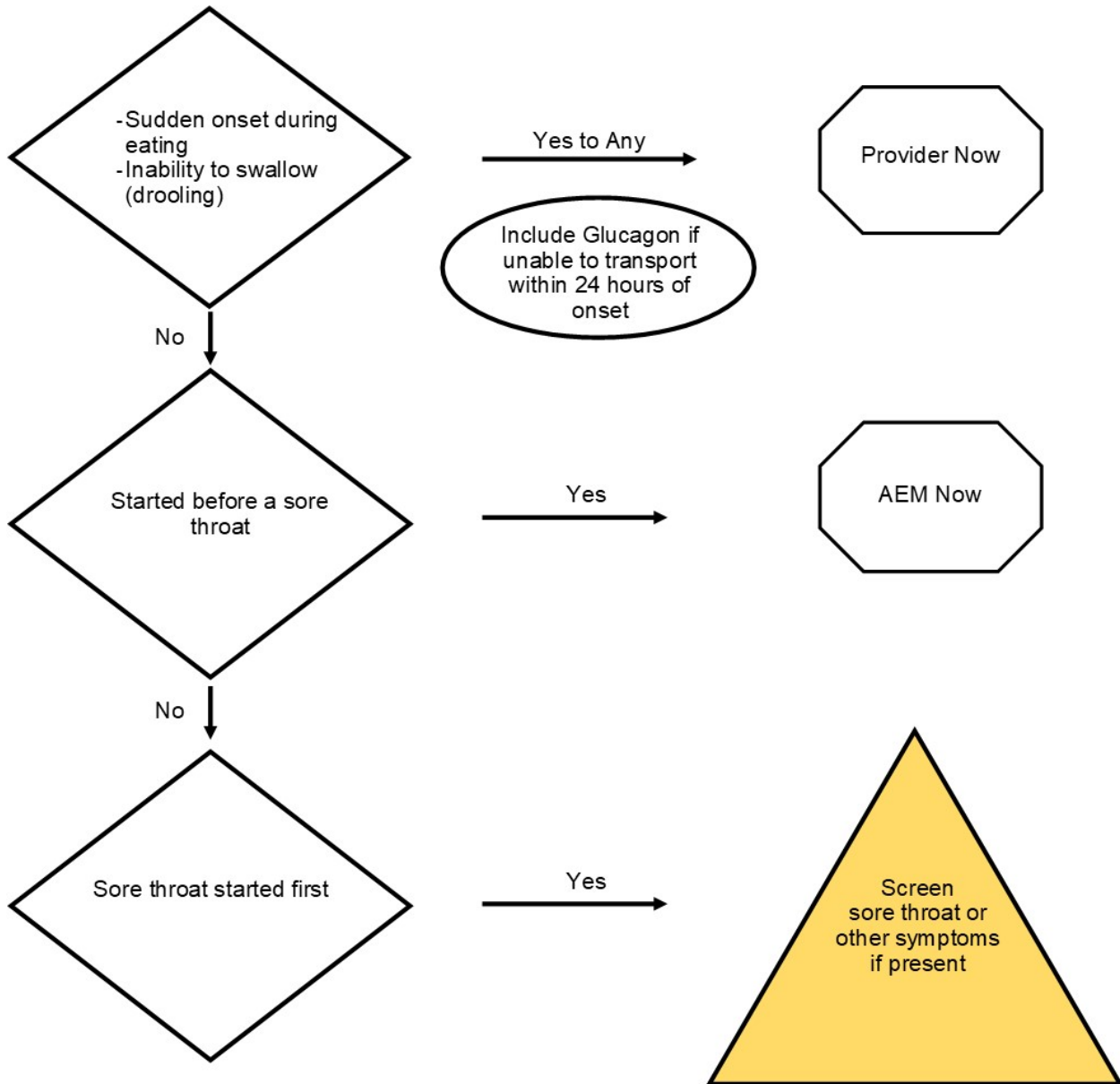
TREATMENT PROTOCOL, C-6

Do not administer meat tenderizers to Soldiers with an esophageal food impaction. It could cause serious esophageal injury. Glucagon can be administered to relax the esophagus as an initial attempt for the Soldier to spontaneously pass the food bolus when a referral for an endoscopic evaluation/ treatment is not available. **Treatment must be prescribed by a supervising privileged provider.**

C-6: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg. 69-70	(2)(k)
C-6: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform a HEENT Exam	081-833-0254

DIFFICULTY WHEN SWALLOWING (DYSPHAGIA), C-6

Partial Differential Diagnosis Food bolus obstruction Esophagitis Ring, Web, Achalasia Throat Infection	RED FLAGS - Airway compromise - Coughing, choking when swallowing	Activity Modification: None
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HEARTBURN, C-7

Heartburn is a common finding but can also be a sign of a more serious condition like a gastric ulcer or heart attack.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1. Angina (substernal chest pressure, worse with exercise), shortness of breath, tachycardia, lightheaded, sweating, shoulder or jaw pain can be signs and symptoms of a myocardial infarction. Obtain an EKG and give aspirin (if no signs of bleeding). Do not wait to provide oxygen, give aspirin, and start IV before notifying the supervising privileged provider. Vomiting blood or coffee grinds and melena are signs of a bleeding ulcer. Tearing pain that radiates to the back is a sign of a dissecting aortic aneurysm.

DP 2. These are symptoms that suggest a more chronic condition than just heartburn. History of an ulcer suggests gastritis or another ulcer. Unexplained weight loss is a sign of cancer. Anorexia and vomiting are signs of pancreatitis. Dysphagia and odynophagia are signs of esophagitis and chronic gastroesophageal reflux disease.

DP 3. Soldier without the previous concerning symptoms and classic heartburn symptoms can be treated with over the counter medications and lifestyle changes. If other symptoms are present, he or she should be screened for those symptoms.

TREATMENT PROTOCOL, C-7

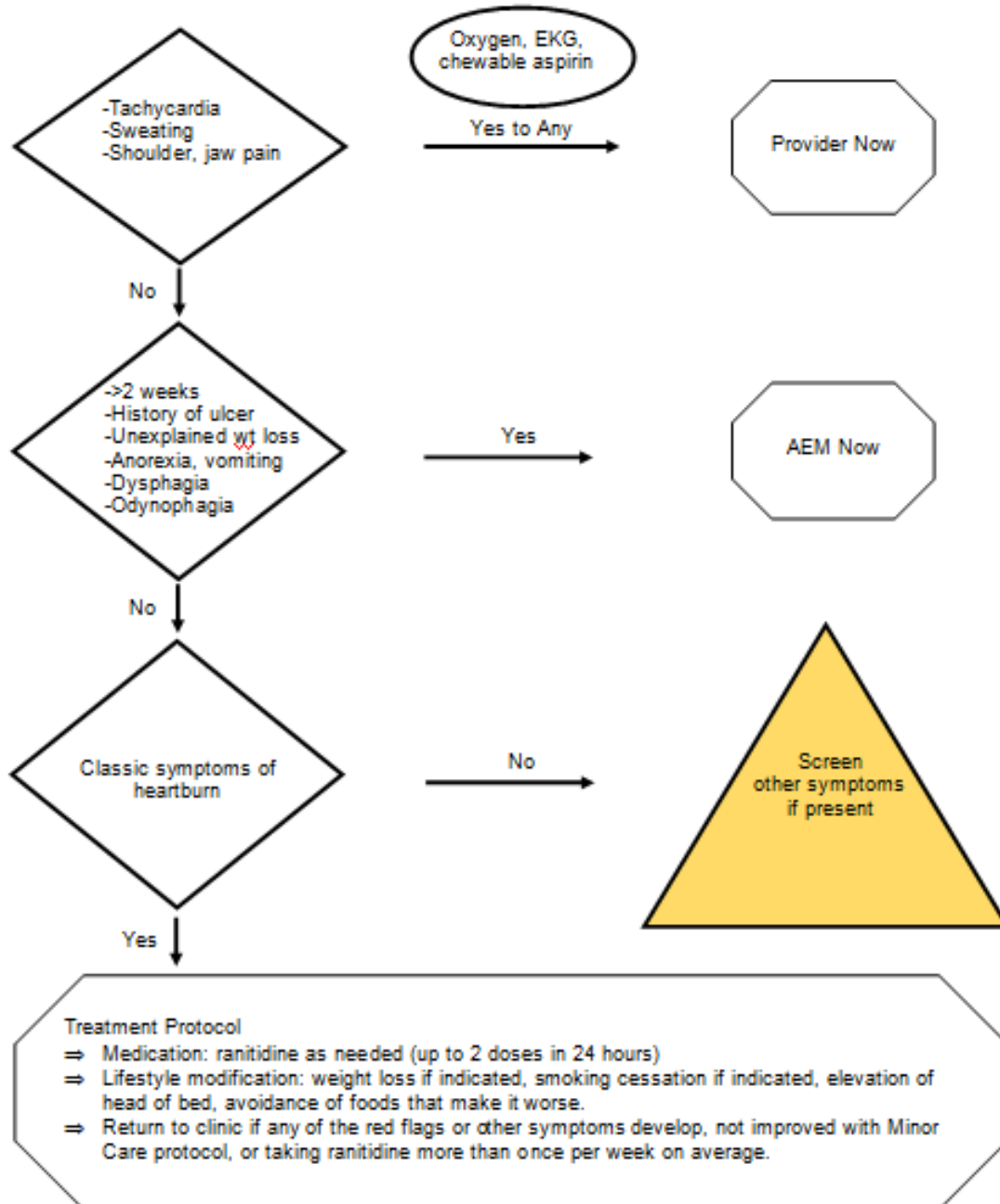
MCP for gastroesophageal reflux. It occurs due to the passage of gastric contents into the esophagus. It is a normal physiologic process that can result in brief episodes of heartburn. Overeating, tobacco, alcohol, overweight, stress, certain foods can act as triggers to increase the frequency of heartburn.

Instruct Soldier on lifestyle modifications: weight loss if overweight, smoking cessation if indicated, and elevation of head of bed, avoidance of chocolate/caffeine/spicy foods/ alcohol/other foods that exacerbate symptoms. Ranitidine (histamine 2 receptor antagonist) as needed for symptoms. Ranitidine reaches peak of action about 2.5 hours after taking and lasts around 8 hours. Return if symptoms are not controlled with minor-care measures, new symptoms arise, or Soldier is having to take the over the counter medication more than once per week.

C-7: In accordance with MEDCOM Regulation 40-50		
Performs 12-lead Electrocardiogram	pg. 69-70	(2)(o-p)
C-7: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 12: Medical Treatment	Obtain an Electrocardiogram	081-833-3007
Subject Area 6: Primary Care	Provide Treatment for Abdominal Disorders	081-833-0239

HEARTBURN, C-7

Partial Differential Diagnosis Gastroesophageal Reflux Myocardial Infarction Stomach/Duodenal Ulcer Cancer Pancreatitis	RED FLAGS - Vomiting Blood or Coffee Grinds - Melena - Angina, SOB - Radiation to Back	Activity Modification: None
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SHORTNESS OF BREATH, D-1

Dyspnea is a sensation of breathing discomfort that can be in respiratory or cardiovascular in nature.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now”. Start the Soldier on oxygen with non-rebreather mask at 10 Liters/ minute, start an IV and IVF at TKO and obtain EKG if available. They can be signs of significant underlying medical problems.

DP 1. Tachycardia, sweating, pain or pressure in the chest, shoulder, or jaw can be symptoms of a myocardial infarction. Chest pain and tachycardia can also be signs of a pulmonary embolism. Irregular pulse identifies an arrhythmia. Do not wait to provide oxygen, give aspirin, and start IV before notifying the supervising privileged provider.

DP 2. Screens for other medical conditions requiring further evaluation. Productive cough and elevated temperature are signs of pneumonia. Symptoms lasting longer than 10 days may not be viral. History of asthma or wheezing screens for an asthma exacerbation.

DP 3. Identifies conditions that are self-limited or can be treated with a minor-care protocol.

TREATMENT PROTOCOL, D-1

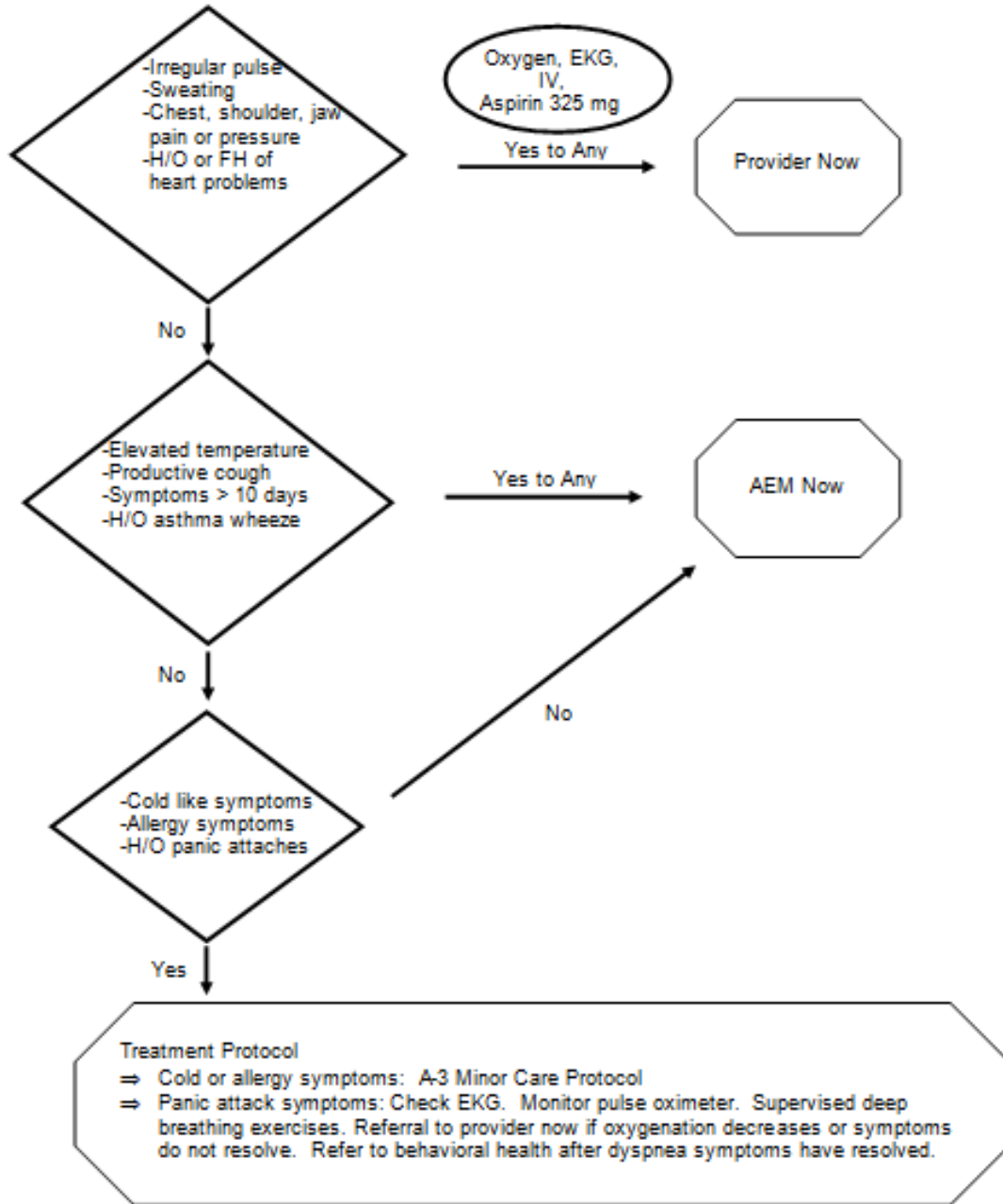
MCP for cold symptoms: Counsel the Soldier to drink plenty of fluids and rest, cover their mouth when they cough and wash hands to prevent spread. Ibuprofen for pain, acetaminophen for elevated temperature, decongestant for nasal congestion, guaifenesin for mucous, or antihistamine for allergies. Return to clinic if not improving within one week, worsening symptoms, **fever, new sinus pain, lightheadedness, or pain in the neck.**

MCP for panic attack symptoms (chest tightness, palpitations, anxious, lightheaded): Check EKG. If EKG is normal, initiate observed deep breathing exercises. Place a pulse oximeter on the Soldier’s finger. Have the Soldier lay back at a 45 degree angle with legs uncrossed and initiate diaphragmatic breathing exercises with deep, slow inhalation over 4 seconds and exhalation over another 4 second count. If the SpO2 starts to drop, disposition the Soldier as “Provider Now”. Refer Soldier to Behavioral Health after initial panic attack decreases in intensity.

D-1: In accordance with MEDCOM Regulation 40-50		
Initiate an Intravenous Infusion	pg.69	(2)(a)
Provide Oxygen	pg.69	(2)(h)
Performs 12-lead Electrocardiogram	pg. 69-70	(2)(o-p)
D-1: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 5: Venipuncture and IV Therapy	Initiate an Intravenous Infusion	081-833-0033
Subject Area 6: Primary Care	Provide Care for Common Respiratory Disorders	081-833-0245

SHORTNESS OF BREATH, D-1

Partial Differential Diagnosis Asthma Anxiety Myocardial Infarction Pulmonary Embolism Pneumonia, Bronchitis Deconditioning	RED FLAGS - Cyanosis - Ancillary muscles - SpO2<90% - SIRS Criteria - Airway Swelling - Hives - Altered Mental Status (AMS)	Activity Modification: Cold Symptoms - Aerobic training at own pace/distance x 3 days - Limit exposure to temperatures below <50 degrees F
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CHEST PAIN, D-2

Chest pain must always be taken seriously. It is a sign of many serious conditions.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now”. Start them on oxygen with a nasal cannula at four-six liters/ minute, start an IV and IVF at TKO, give a chewable aspirin. These can be signs of significant underlying medical problems.

DP 1. Obtain an EKG if available. Tachycardia, sweating, pain, and pressure in the chest, shoulder, or jaw can be symptoms of a myocardial infarction. Note that diabetics and women can present atypically. Chest pain and tachycardia can also be signs of a pulmonary embolism or arrhythmia. Do not wait to provide oxygen, give aspirin, and start IV before notifying the supervising privileged provider.

DP 2. Elevated temperature and productive cough screens for pneumonia. Recent chest trauma screens for multiple etiologies to include a rib fracture.

DP 3. Conditions that are not identified below should be referred to the AEM for further evaluation.

TREATMENT PROTOCOL, D-2

MCP for cold symptoms. See Protocol A-3.

MCP for panic attack symptoms (chest tightness, palpitations, anxious, lightheaded): Check EKG. If EKG is normal, initiate observed deep breathing exercises. Place a pulse oximeter on the Soldier’s finger. Have the Soldier lay back at a 45 degree angle with legs uncrossed and initiate diaphragmatic breathing exercises with deep, slow inhalation over 4 seconds and exhalation over another 4 second count. If the SpO2 starts to drop, disposition the Soldier as “Provider Now”. Refer Soldier to behavioral health after initial panic attack decreases in intensity.

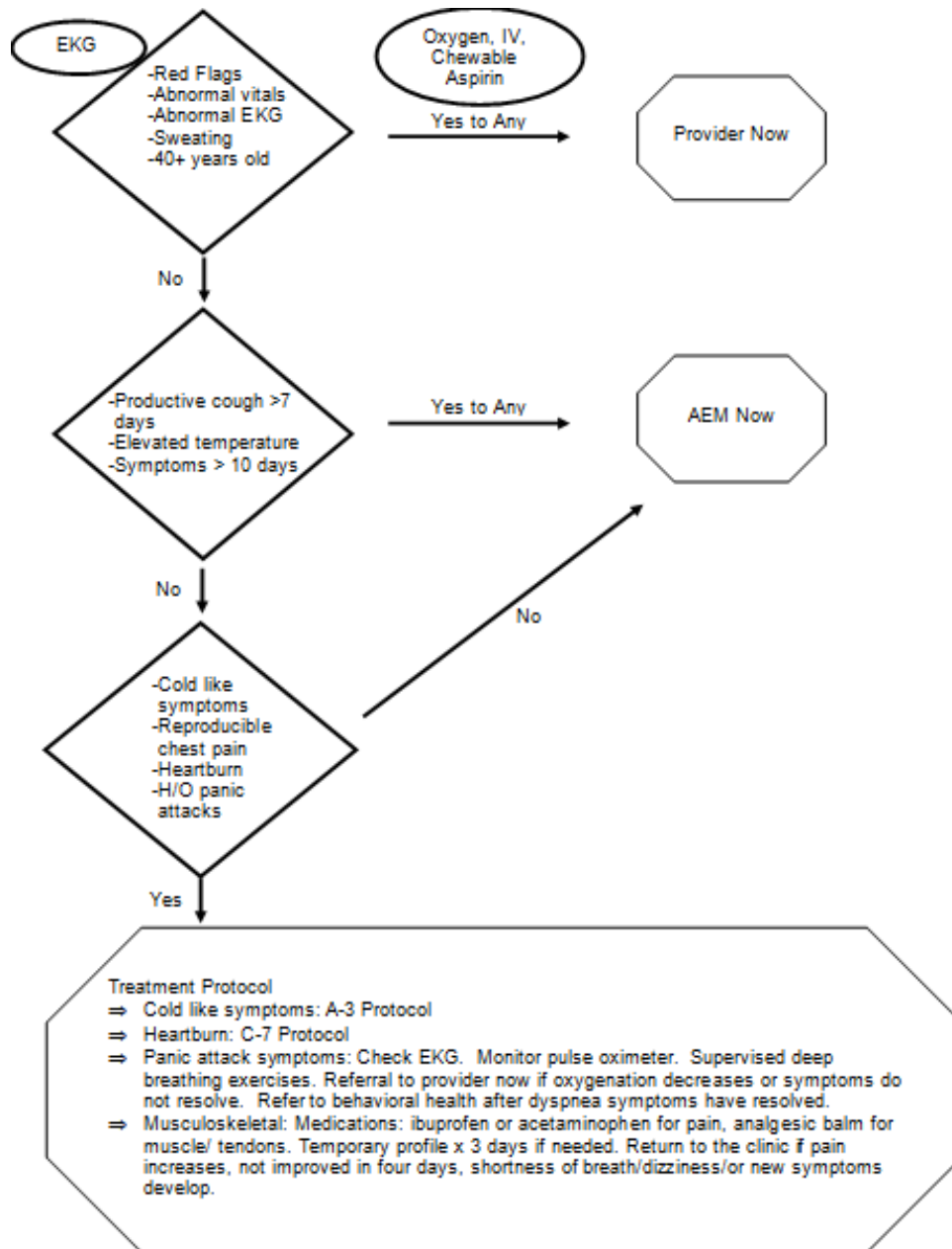
MCP for musculoskeletal chest pain: Pain must be reproducible and directly correspond to a supporting history. Medications: ibuprofen as needed for muscle complaints. Return to clinic if pain increases, lasts longer than three days, shortness of breath/ dizziness/ or new symptoms develop. **Must discuss with supervising privileged provider before Soldier leaves screening area.**

MCP for heartburn: See Protocol C-7.

D-2: In accordance with MEDCOM Regulation 40-50		
Initiate an Intravenous Infusion	pg.69	(2)(a)
Provide Oxygen	pg.69	(2)(h)
Performs 12-lead Electrocardiogram	pg. 69-70	(2)(o-p)
D-2: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 12: Medical Treatment	Obtain an Electrocardiogram	081-833-3007
Subject Area 4: Airway Management	Administer Oxygen	081-833-0158

CHEST PAIN, D-2

<p>Partial Differential Diagnosis Myocardial Infarction Pulmonary Embolism Pneumonia, Bronchitis Anxiety Heartburn Musculoskeletal</p>	<p>RED FLAGS - Irregular Pulse - H/O or FH of Heart Problems - Shoulder, jaw pain or pressure</p>	<p>Activity Modification: MSK Chest Pain - May lift, push up to 25 lbs Cold Symptoms - Aerobic training at own pace/distance x 3 days - Limit exposure to temperatures below <50 degrees F</p>
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PAINFUL/FREQUENT URINATION, E-1

Painful urination is most commonly a sign of a urinary tract infection, kidney stone, sexually transmitted infection, or yeast infection. Frequent urination can be associated with these but can also be one of the initial signs of hyperglycemia from diabetes.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1. Urinary tract infections can get worse if not promptly treated. Urinary tract infection can progress to a kidney infection and then a systemic infection through the blood. Uncontrolled diabetes can present with increased urination and nausea with vomiting. Complaints requiring an invasive exam are referred to the supervising privileged provider.

DP 2. Urinary complaints in a male are more likely to be something other than a urinary tract infection. Recurrent urinary tract infections (UTIs), recent urinary catheterization, and immunocompromised are more likely to have an atypical bacterial infection.

TREATMENT PROTOCOL, E-1

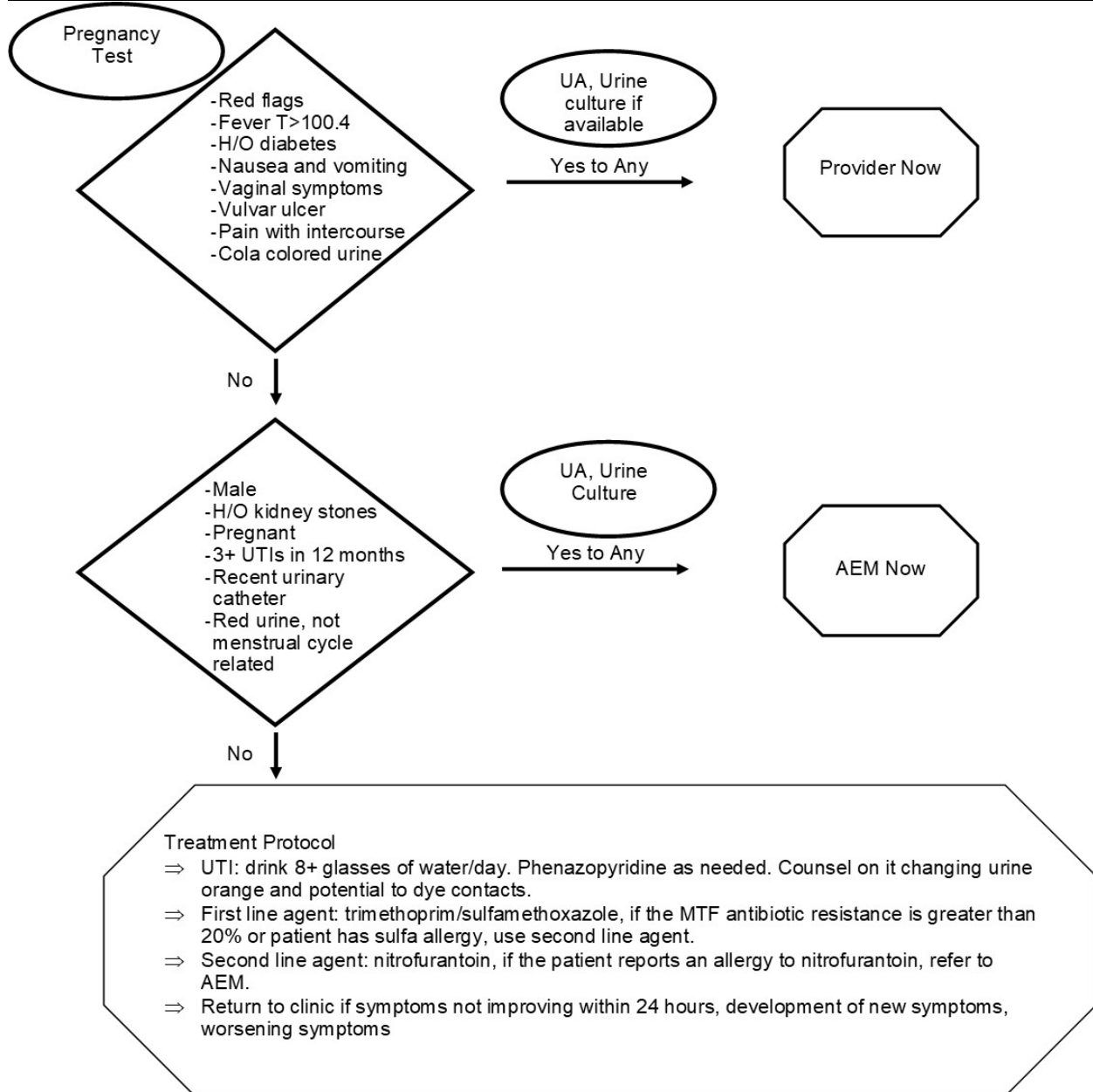
UA and urine culture should be completed if resources are available. A Soldier with symptoms consistent with a UTI can be empirically treated without a urinalysis after ruling out any history that would increase the Soldier’s risk and determining any allergies to medications.

MCP for UTI. Instruct the Soldier about the importance of increasing fluid intake to flush out the bacteria. OTC medication: phenazopyridine as needed for pain. Instruct the Soldier that it will likely dye his or her urine orange. It may also stain contact lenses from transferring the dye from the fingers to the contacts, if worn. Antibiotics: Trimethoprim/ Sulfamethoxazole is the first line agent. Nitrofurantoin is the second line agent if the Soldier is allergic to sulfa drugs or there is local resistance to the first line agent. Return to clinic if symptoms are not improving within 24 hours, development of new symptoms, or worsening symptoms despite treatment.

E-1: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg. 69-70	(2)(k)

PAINFUL/FREQUENT URINATION, E-1

Partial Differential Diagnosis Kidney Infection Urinary Tract Infection Kidney Stone Uncontrolled Diabetes BPH STI, Vaginitis	RED FLAGS - Systemic Inflammatory Response Syndrome - Flank Pain - Severe Abdominal Pain - Gross Hematuria or Passing Blood Clots	Activity Modification: None
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GROIN/TESTICULAR PAIN or URETHRAL DISCHARGE, E-2

This term may be described as pain in the testes or groin. Look for visual cues and orient the Soldier to the pain scale prior to defining the level of pain.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Severe pain at rest with the testes supported can be a sign of testicular torsion or a hernia. Immediate referral is needed for further evaluation and potential treatment. Pain with standing or increasing during exercise can be a sign of a stress fracture of the hip. Change in activity or endurance training are risk factors for a stress fracture. Suspected stress fractures should be toe touch weight bearing and get immediate evaluation. Nausea and vomiting could represent severe pain or be a sign of a hernia.

DP 2: Pain that has lasted for over 2 weeks is less likely to be an acute muscle strain and could represent an injury to the hip joint requiring further evaluation. Urologic symptoms, like hematuria, require further evaluation.

TREATMENT PROTOCOL, E-2

MCP for epididymitis. Pain is often improved with testicular support. Instruct the Soldier on the importance of wearing supportive underwear (briefs, jock strap), application of ice to decrease the swelling. Medication: ibuprofen, acetaminophen, topical muscle balm, ice and heat as needed for pain, inflammation, and swelling or ketorolac for moderate pain. Activity modification.

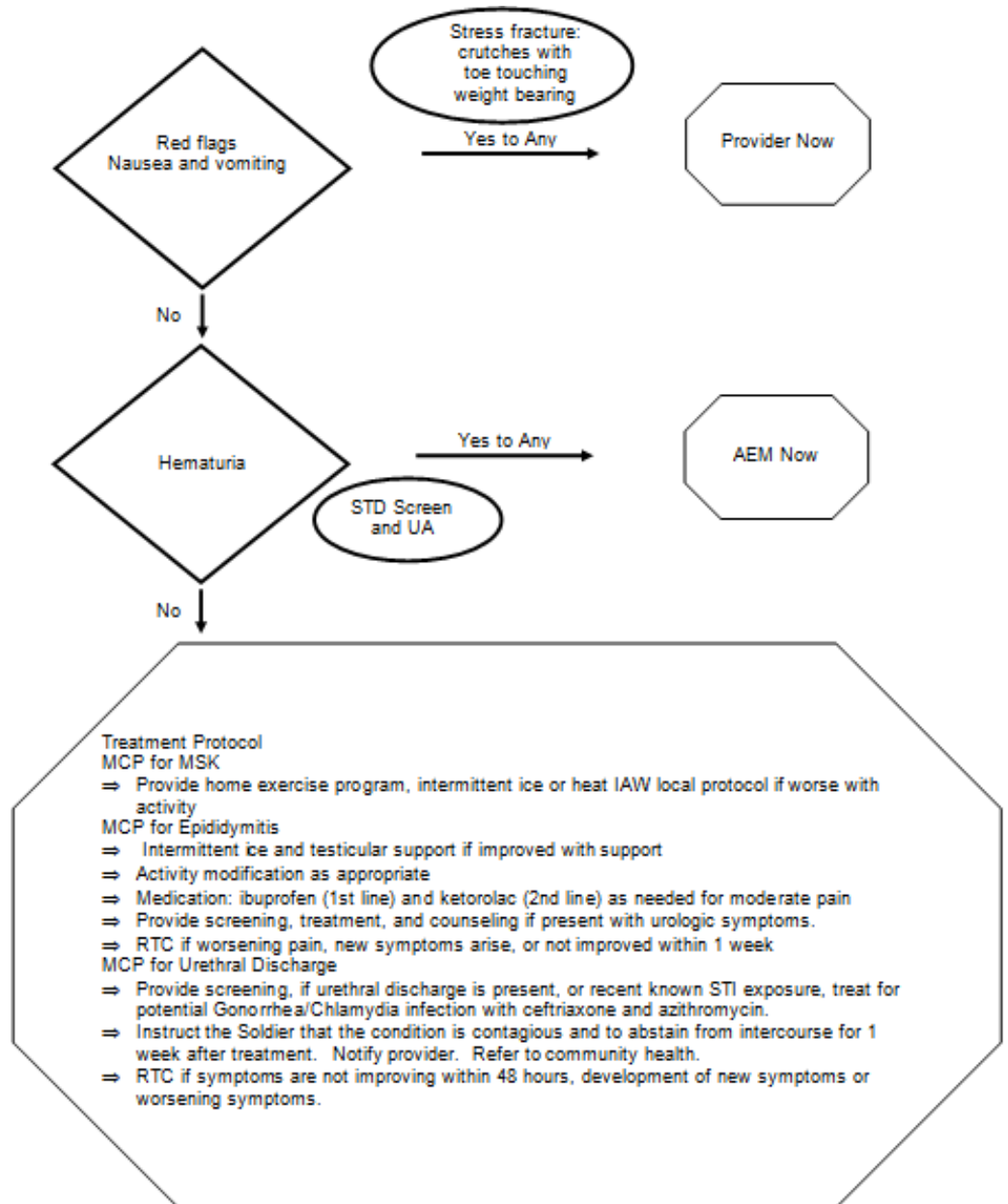
MCP for muscle/tendon strain. Pain is often worse with activity. Instruct the Soldier on the home exercise program in accordance with local protocol. Medication: ibuprofen, acetaminophen, topical muscle balm, ice and heat as needed for pain, inflammation, and swelling or ketorolac for moderate pain. Activity modification.

MCP for urethral discharge. Request an order for a urinalysis and gonorrhea/chlamydia urine screen. If urethral discharge is present, 2+ white blood cells (WBCs) on urinalysis, leukocyte esterase positive on urinalysis, or recent known STI exposure, treat for potential gonorrhea/chlamydia infection with ceftriaxone and azithromycin. Instruct the Soldier that the condition is contagious and to abstain from intercourse for 1 week after treatment. Notify the supervising privileged provider so that he or she can track. Refer to community health. Return to clinic if symptoms are not improving within 48 hours, development of new symptoms, or worsening symptoms.

E-2: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
Obtain Laboratory Specimens	pg.69-70	(2)(k)
Gathers Sexually Transmitted Infection Specimen	pg.69-70	(2)(n)

GROIN/TESTICULAR PAIN or URETHRAL DISCHARGE, E-2

Partial Differential Diagnosis Testicular Torsion Hernia Muscle/Tendon Strain Stress Fracture Hip injury	RED FLAGS - Pain with testes supported - Suspect Stress Fracture (increased with weight bearing or during exercise, endurance training, change in exercise routine) - Severe Pain	Activity Modification: Epididymitis - Walk at own pace/distance - No running, jumping, riding in military vehicle over uneven terrain - May stand for up to 15min
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SEXUALLY TRANSMITTED INFECTION (STI), E-3

Soldiers frequently show concern that they may have (STIs); however, they seldom use that term. For screening purposes, focus on the symptom(s), or in the absence of symptoms, the belief that they may have been exposed to infections through sexual contact. Sexually transmitted infections include but are not limited to those traditionally classified as venereal diseases. Some are potentially life-threatening; others are not. Some infections can be cured through treatment; others cannot be cured at the present time. Sometimes symptomatic relief is available. All Soldiers, with or without symptom(s), need to be evaluated.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: All Soldiers will be screened with a pregnancy test (if female), UA, and STI screen. STI screen will consist of a RPR, gonorrhea/chlamydia urine screen, and HIV screen. Pelvic pain with intercourse may be pelvic inflammatory disease. Orthostatic symptoms, fever, and signs of a severe illness can represent a more significant problem. Signs of a severe illness includes abnormal vital signs, appearing pale, sweaty, lethargic, or visually in pain. Failure of initial treatment may be a drug resistant organism. Females with vaginal symptoms to include discharge will be referred to a privileged provider for a pelvic examination.

DP 2: Skin lesions/rash may represent a chancre (syphilis), HSV ulcers, genital warts (HPV), chancroid, or molluscum contagiosum. Further evaluation is necessary to determine the necessary treatment modality (freezing, medication, or referral).

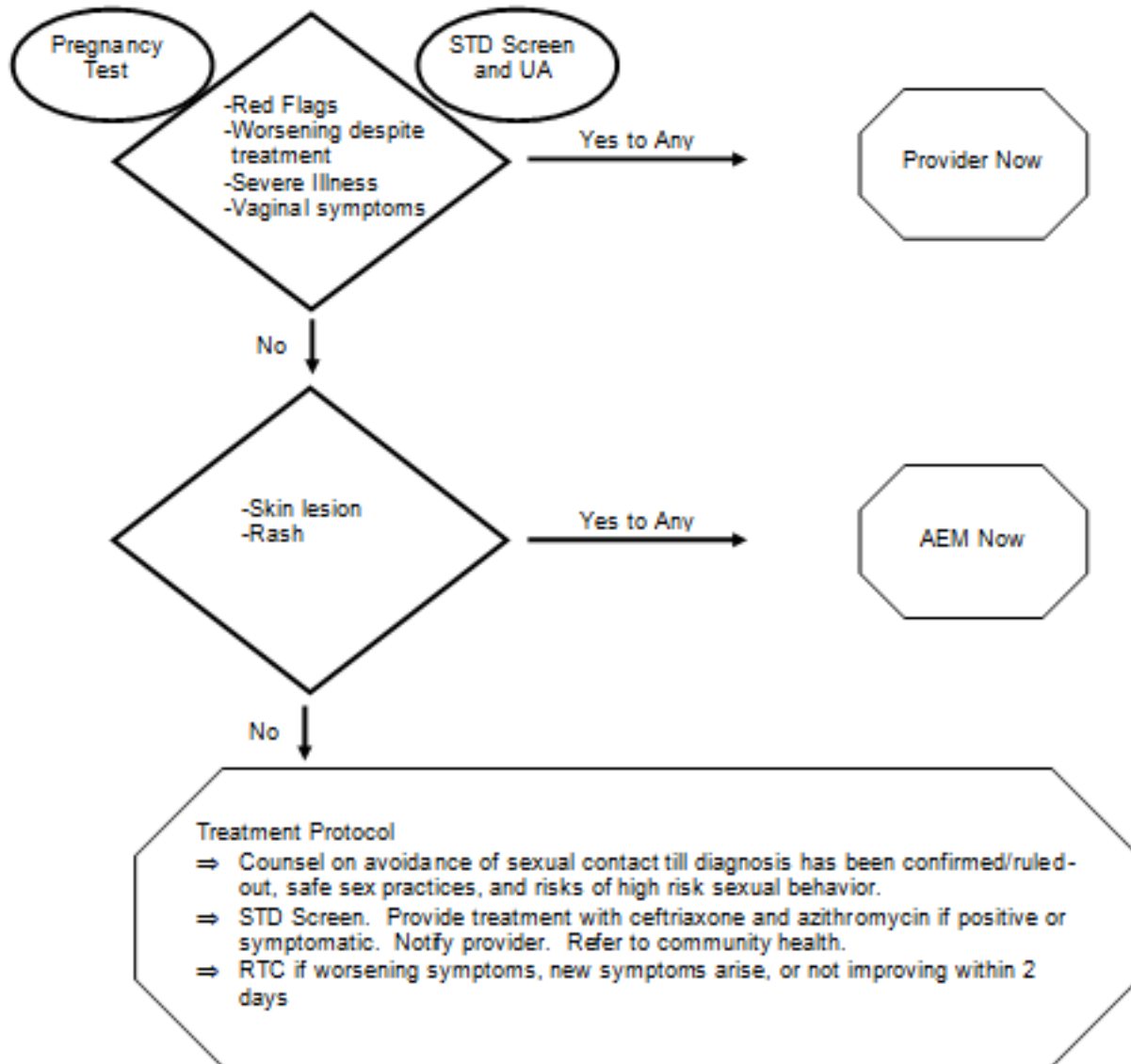
TREATMENT PROTOCOL, E-3

MCP for urethral discharge. Request an order for a urinalysis and gonorrhea/chlamydia urine screen. If urethral discharge is present, 2+ WBC on urinalysis, leukocyte esterase positive on urinalysis, or recent known STI exposure, treat for potential gonorrhea/chlamydia infection with ceftriaxone and azithromycin. Instruct the Soldier to abstain from intercourse for one week after treatment due to contagious risk and counsel on safe sex practices and risks of high risk sexual behavior. Notify the supervising privileged provider so that he or she can track. Refer to community health. Return to clinic if symptoms are not improving within 48 hours, development of new symptoms, or worsening symptoms.

E-3: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg.69-70	(2)(k)
Gathers Sexually Transmitted Infection Specimen	pg.69-70	(2)(n)
E-3: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 15: Primary Care	Utilize a Urine Test Strip	081-833-0255

SEXUALLY TRANSMITTED INFECTION (STI), E-3

Partial Differential Diagnosis Testicular Torsion Hernia Muscle/Tendon Strain Stress Fracture Hip injury	RED FLAGS - Female Pelvic Pain with Intercourse - Pregnant - Orthostatic, Fever	Activity Modification: None
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PROBLEMS WITH VOIDING, E-4

Problems with voiding may include urinary incontinence (voiding unintentionally), difficulty initiating the urinary stream, decreased force of the stream, dribbling urination, complete inability to void.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Inability to void can represent an obstruction of the ureter. Do to the risks to the kidneys, it is a medical emergency.

DP 2: A man’s prostate can become enlarged later in life resulting in urinary symptoms of post-void urine dribbling, a weak stream, or difficulty initiating a urinary stream that requires further evaluation and treatment by a qualified provider.

TREATMENT PROTOCOL, E-4

MCP for urethral discharge. See Protocol E-3. Check a first morning void urinalysis and gonorrhea/chlamydia urine screen. If indicated, treat for potential gonorrhea/chlamydia infection with ceftriaxone and azithromycin. Instruct the Soldier to abstain from sex due to the contagious risk. Notify the supervising privileged provider. Refer to community health. RTC if symptoms have not improved in 1 week, symptoms worsen, or new symptoms develop.

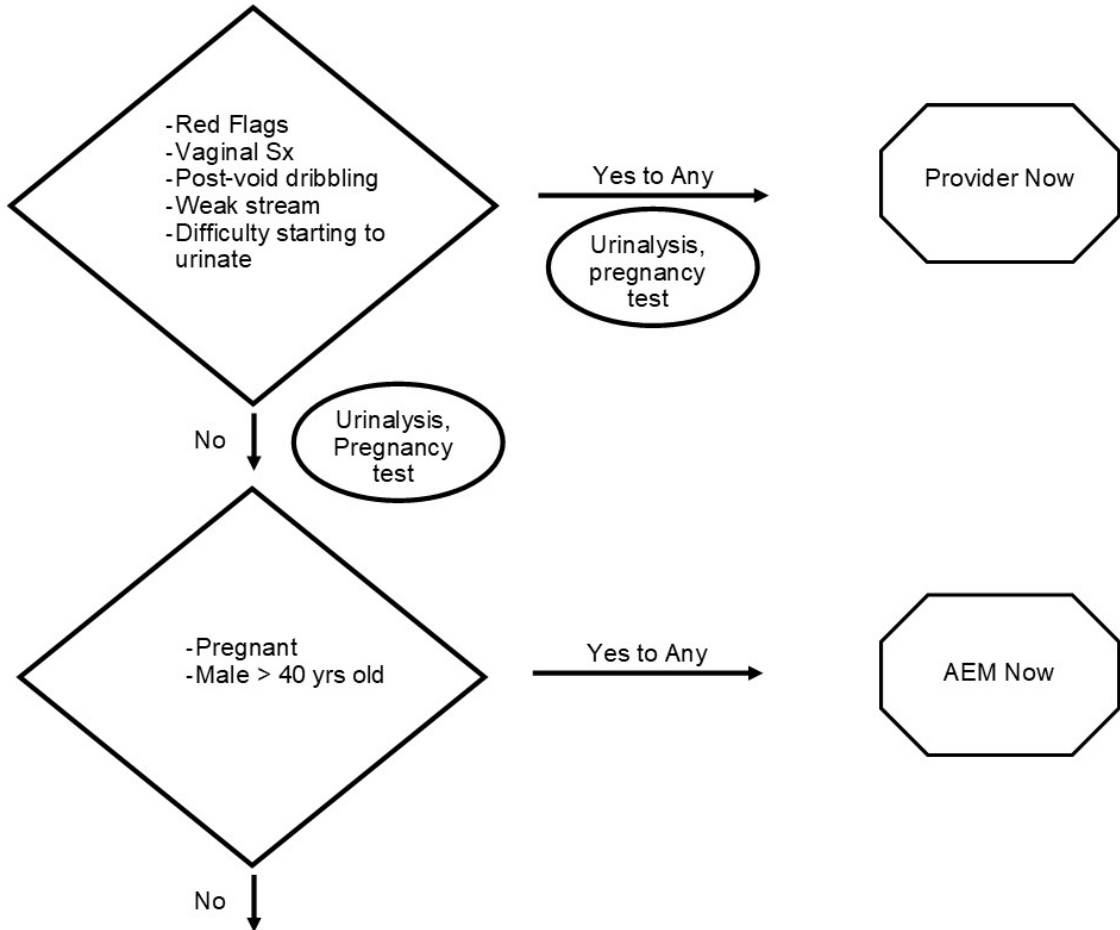
MCP for UTI. See Protocol E-1. OTC medication: phenazopyridine as needed for pain. Antibiotics: trimethoprim/sulfamethoxazole is the first line agent. Nitrofurantoin is the second line agent. Return to clinic in 24 hours if symptoms are not improving, worsening symptoms, or developing new symptoms.

MCP for urinary incontinence. If leaking urine during episodes of increased intra-abdominal pressure (sneezing, coughing, laughing, jumping), it is stress incontinence. Instruct the Soldier on performing Kegel exercises at home. Contact the clinic if not improving and would like a referral. Return for worsening or development of new symptoms.

E-4: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg.69-70	(2)(k)
Gathers Sexually Transmitted Infection Specimen	pg.69-70	(2)(n)
E-4: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 15: Primary Care	Utilize a Urine Test Strip	081-833-0255

PROBLEMS WITH VOIDING, E-4

Partial Differential Diagnosis Urinary Obstruction Benign Prostatic Hypertrophy UTI, STI Stress Incontinence	RED FLAGS - Inability to void x 12 hours - Fever - Cola Colored Urine - Blood or Clots in Urine	Activity Modification: Incontinence - Access to a Restroom - No jumping
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Treatment Protocol

- ⇒ If urethral discharge is present, use SCP E-3.
- ⇒ If UA is leukocyte esterase positive, 2+ WBCs, or UTI symptoms in a female, use SCP E-1
- ⇒ If leaking urine when coughing, sneezing, jumping, counsel patient on home exercises.
- ⇒ RTC if worsening symptoms, new symptoms arise, or not improved within stated timeframe

DIZZINESS/FAINTNESS/BLACKOUT, F-1

It is useful to try and distinguish among different presentations of dizziness: faintness, blackouts, vertigo, confusion, malaise, muscle weakness, and other sensations. True vertigo refers to an illusion where the room seems to be spinning about or the floor seems to be moving. It may be likened to the feeling experienced immediately after getting off a fast merry-go-round and is often accompanied by nausea. Faintness or light-headedness is a feeling of unsteadiness or beginning to fall. Blackout refers to a complete loss of consciousness and observers should also be questioned about potential causes of the event and any unusual observations during the event.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Take orthostatic blood pressure. Severe headache associated with trauma can represent an intracranial bleed. Heat injuries can be life-threatening and require prompt action. Soldier acting abnormal or intoxicated, with abnormal pupils, an unsteady gait, loss of coordination, slurred speech, or appearing unkempt should be referred for further evaluation. Hypo/hyperglycemia can also result in altered mental status and progress to a coma.

DP 2: Anxiety with hyperventilation can result in dizziness. Soldiers with vertigo will require further evaluation and medications for treatment.

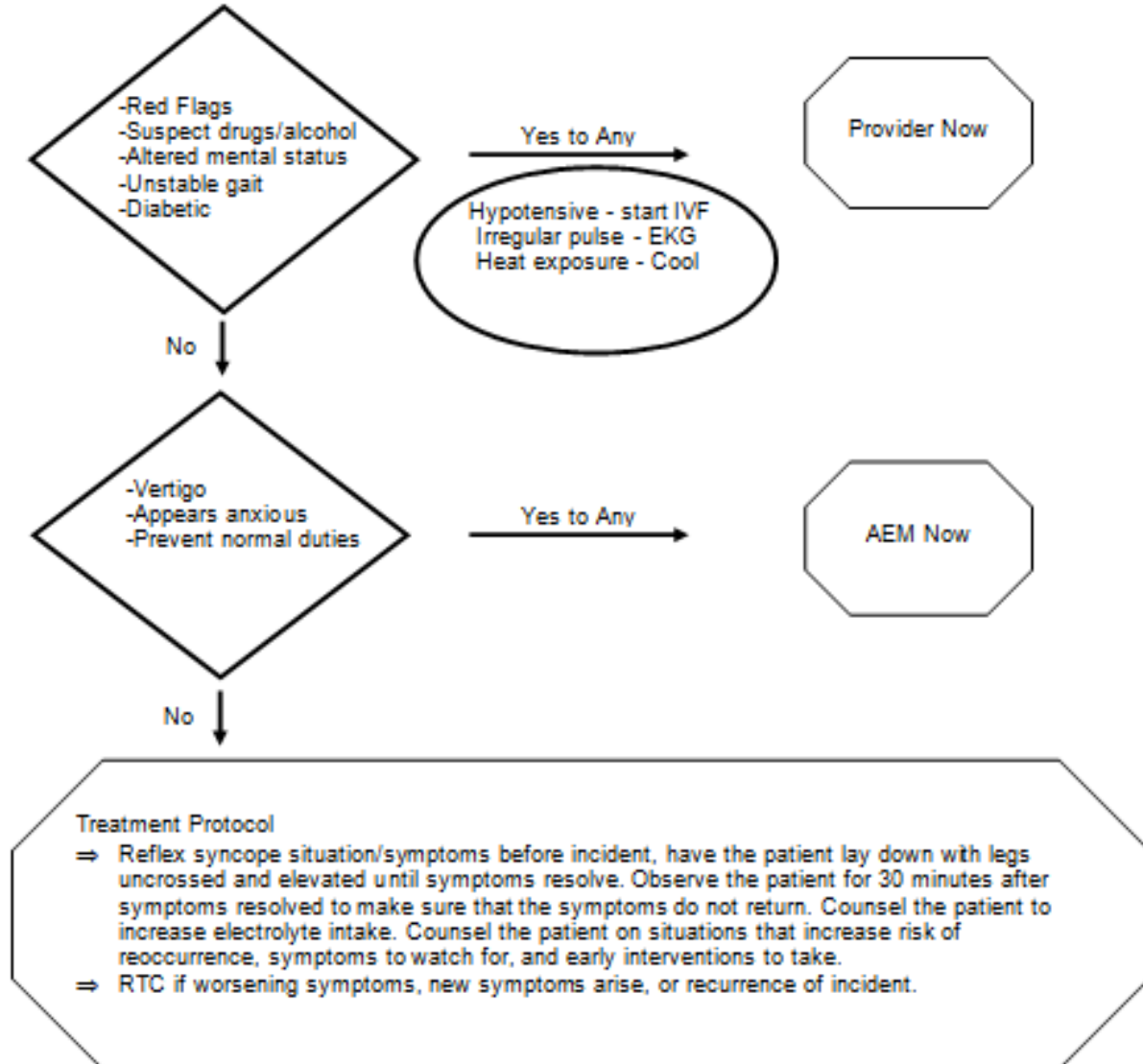
TREATMENT PROTOCOL, F-1

MCP for syncope. Common reflex syncope situations include prolonged standing in formation, seeing/ giving blood, or especially stressful situation. Have the Soldier lay down in a comfortable position and elevate the legs, if possible. Continue to monitor the Soldier for 30 minutes after the symptoms have resolved. Reassure the Soldier that it is a common and benign condition. Instruct the Soldier to increase water and salt intake, watch for the prodromal signs (lightheaded, flushing/ feeling of warmth, sweating, tunnel vision/ changes in vision progressing to blindness, nausea, appearing pale), and actions to take when the symptoms start. Laying down with the legs raised or sitting when not able to lay down, clenching the fist, or leg pumping (crossing and flexing legs) or some ways that can help relieve symptoms.

F-1: In accordance with MEDCOM Regulation 40-50		
Initiate an Intravenous Infusion	pg.69	(2)(a)
Initial Treatment of Environmental Injuries	pg.69	(2) (e)
Provide Oxygen	pg.69	(2)(h)
Performs 12-lead Electrocardiogram	pg. 69-70	(2)(o-p)
F-1: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 12: Medical Treatment	Obtain an Electrocardiogram	081-833-3007
Subject Area 5: Venipuncture and IV Therapy	Initiate an Intravenous Infusion	081-833-0034
Subject Area 11: Force Health Protection	Initiate Treatment for a Heat Injury	081-833-0038

DIZZINESS/FAINTNESS/BLACKOUT, F-1

Partial Differential Diagnosis Orthostatic Hypotension Vasovagal Syncope Vertigo Anxiety Heart Arrhythmia Intracranial Bleed Seizure, Drugs, Alcohol	RED FLAGS - Abnormal Vital Signs - Irregular Pulse - Witnessed or H/O Seizure - Severe Headache - Heat Injury	Activity Modification: No Driving x 72 hours
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HEADACHE, F-2

In the absence of fever, severe pain, or confusion, serious disease is extremely unlikely. Migraines often present with a gradual, increasing onset of a one sided, pulsatile moderate to severe headache worse with physical activity, noise, or light and associated with nausea and may have an aura. Tension-type headache often presents as a bilateral pressure that waxes and wanes lasting from 30 min to seven days. Cluster headache is rare. It presents with a rapid onset within minutes of unilateral deep, continuous severe pain around the eye or temple often associated with tearing, congestion, runny nose, pallor, or sweating.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Severe hypertension is a blood pressure over 220 systolic or 110 diastolic. When a Soldier has severe hypertension, have them lay down in a quiet, dark room until able to transport them to a higher level of care. A blown pupil can be a sign of increased intracranial pressure. Sudden worst headache of the Soldier’s life and focal neurological sign can be a sign of an intracranial hemorrhage. Fever and inability to touch the chin the chest are signs of meningitis. Altered mental status can be a sign of a more significant problem. If there is some question as to whether or not the Soldier is confused, ask him simple questions such as his name, day of the week, the year, where he is now, or who is the President of the United States?

DP 2: Nausea is a common symptom with a migraine headache but can also be a sign of increased intracranial pressure. Nausea requires a further evaluation to determine the most likely cause. Uncontrolled high blood pressure can result in a headache and requires additional treatment. Headaches that have failed initial treatment need to be evaluated for secondary causes and a different medication regiment. A change from a Soldier’s usual headache can represent a more significant underlying medical problem or new cause of the headache. Pregnancy limits the medications that can be used, and headache in pregnancy could represent pre-eclampsia if over 20 weeks pregnant.

TREATMENT PROTOCOL, F-2

MCP for headache. Provide the Soldier with ibuprofen, naproxen, or ketorolac as needed for his or her headache. Return to clinic if confusion, vision problems, nausea, or fever develop, if the pain is so severe that performance of normal duties is impossible, or the headache lasts over 24 hours. May provide physical activity modification for one day, if necessary.

HEADACHE, F-2

Partial Differential Diagnosis Migraine Headache Tension Headache Caffeine Withdrawal Infection/Meningitis Intracranial Hemorrhage	RED FLAGS - Sudden Onset, Severe - Focal Neurologic Signs - Blown pupil - Severe Hypertension - Fever - Vision Change/Loss	Activity Modification: - May wear Sunglasses Indoors - Limit loud noises - Walk at own pace/distance - No running, rucking, jumping
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NUMBNESS/TINGLING/PARALYSIS/WEAKNESS, F-3

“Numbness” may be used by the Soldier to describe muscle weakness, malaise, confusion, or abnormal sensation including tingling (a “pins and needles” sensation). Paralysis/weakness is a condition that refers to a loss of muscular strength resulting in difficulty or inability to move a body part. A complete loss of muscular strength is paralysis; a partial loss is weakness.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Localized issue is more likely to have a serious cause than generalized symptoms. Back pain can represent a herniated disc causing nerve compression. Severe headache can represent an intracranial lesion. Insulin use, or history of diabetes can present with symptomatic hypoglycemia. In hypoglycemic Soldiers, sugar or food should be provided if available.

DP 2: Fatigue from an infectious illness can be described as weakness. First occurrence of symptoms or being 35 years old or older may indicate a higher risk for a more serious condition. Depression can also present as weakness.

TREATMENT PROTOCOL, F-3

MCP for hyperventilation (respiratory rate greater than 14 per minute). Provide reassurance to the patient. Have the Soldier practice relaxed breathing. If symptoms do not resolve within 10 minutes, refer to AEM. If symptoms resolve, refer to behavioral health if available.

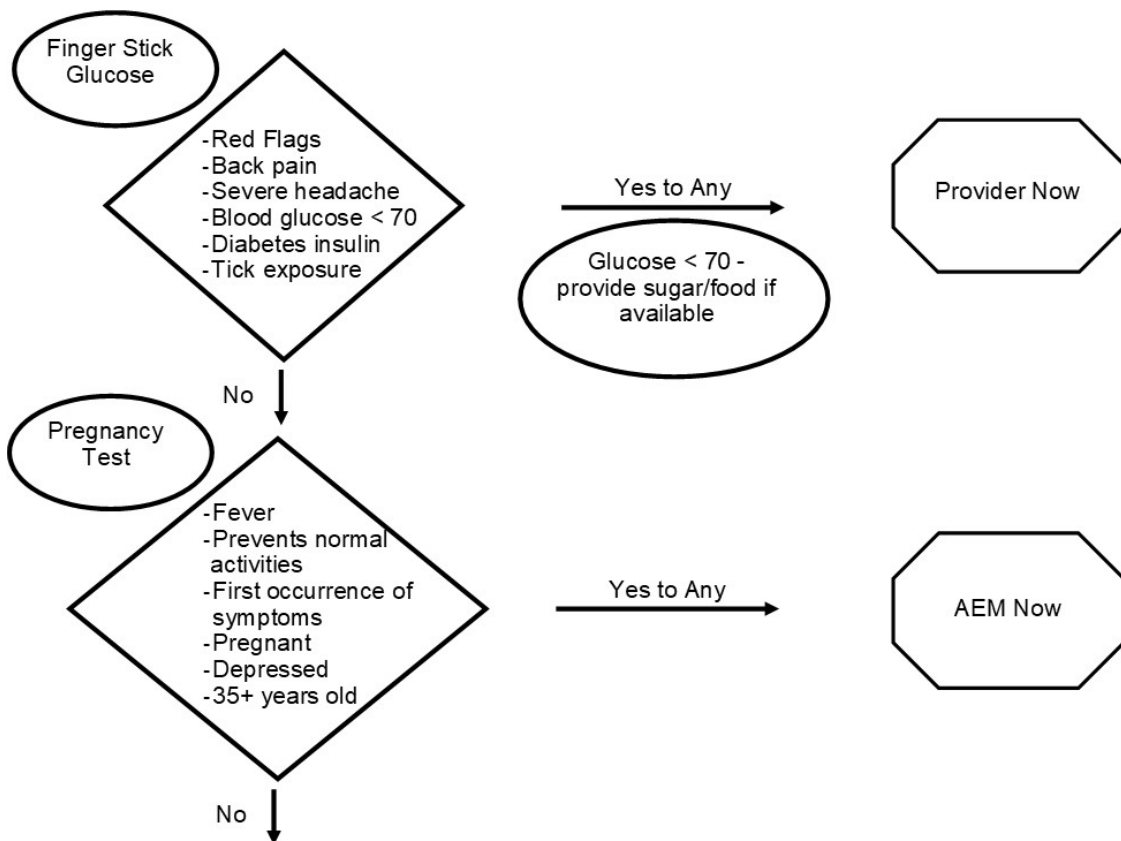
MCP for viral syndrome. Viral syndrome can present as fatigue described as weakness. It is a global feeling often associated with other symptoms and muscle aches. Treat in accordance with related protocol.

MCP for sleep issues. Sleep issues can present as fatigue described as weakness. It can be a manifestation of depression or stress among other things. Provide education on sleep hygiene, consider providing diphenhydramine or melatonin nightly for three nights, consider activity modification, discuss stress management, and offer a routine referral to behavioral health asset for counseling and treatment.

F-3: In accordance with MEDCOM Regulation 40-50		
Obtain Blood Glucose Levels	pg.69	(2)(f)
F-3: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 15: Primary Care	Operate a Glucometer	081-833-0257

NUMBNESS/TINGLING/PARALYSIS/WEAKNESS, F-3

Partial Differential Diagnosis Viral Syndrome/ Fatigue Stroke Nerve Compression Hypoglycemia Hyperventilation Depression Lyme disease	RED FLAGS - Localized to a Region or 1 sided - Recent Trauma - Loss of Consciousness - Bowel/Bladder Incontinence	Activity Modification: Insomnia -Allow for 8 hours of uninterrupted sleep in 24 hour period Viral Syndrome -PT training at own pace/ rep/ distance x 3 days
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Treatment Protocol

- ⇒ Hyperventilation: respiratory rate greater than 14 per minute. Provide reassurance to the patient. Have the Soldier practice relaxed breathing. If symptoms do not resolve within 10 minutes, refer to AEM. If symptoms resolve, refer to behavioral health if available.
- ⇒ Viral Syndrome: ibuprofen as needed for fatigue/body aches. Drink plenty of water. Get plenty of sleep.
- ⇒ Insomnia/Fatigue/Stress: provide sleep hygiene education, recommend self-reflection to find a way to relieve stress, and offer a routine referral to a routine behavioral health asset, if available.
- ⇒ Return to clinic if not improving, new symptoms arise, or symptoms are worsening.

DROWSINESS/CONFUSION, F-4

Drowsiness and confusion are symptoms that may be observed even when the Soldier is relating other complaints. Drowsiness and confusion may be related to many underlying issues to include systemic illness, organ dysfunction, drug intoxication/ withdrawal, psychiatric illness, trauma, or neurologic illness.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Abnormal vital signs may represent a more significant condition to include shock. Soldiers with an altered mental status should have their finger stick blood sugar checked. Hypoglycemia can cause an altered mental status. Focal neurological deficits and a recent trauma suggest intracranial pathology. Alcohol, narcotics, and other drugs can cause confusion through intoxication or withdrawal. Seizures can cause confusion even if the rhythmic jerking movements are not presenting in the Soldier.

DP 2: Sudden onset of symptoms is more concerning. Heat exhaustion, heat injury, and heat stroke can be associated with drowsiness or confusion. If a heat exposure is of concern, then a rectal temperature must be checked. Alternative methods of checking the temperature can be inaccurate. Alcohol, drug, or medication exposure or withdrawal can cause drowsiness. Some medications that can cause drowsiness include antihistamines, sleep medications, muscle relaxants, analgesics, and psychiatric medications.

TREATMENT PROTOCOL, F-4

If drowsiness or confusion is not from a condition below, refer to AEM.

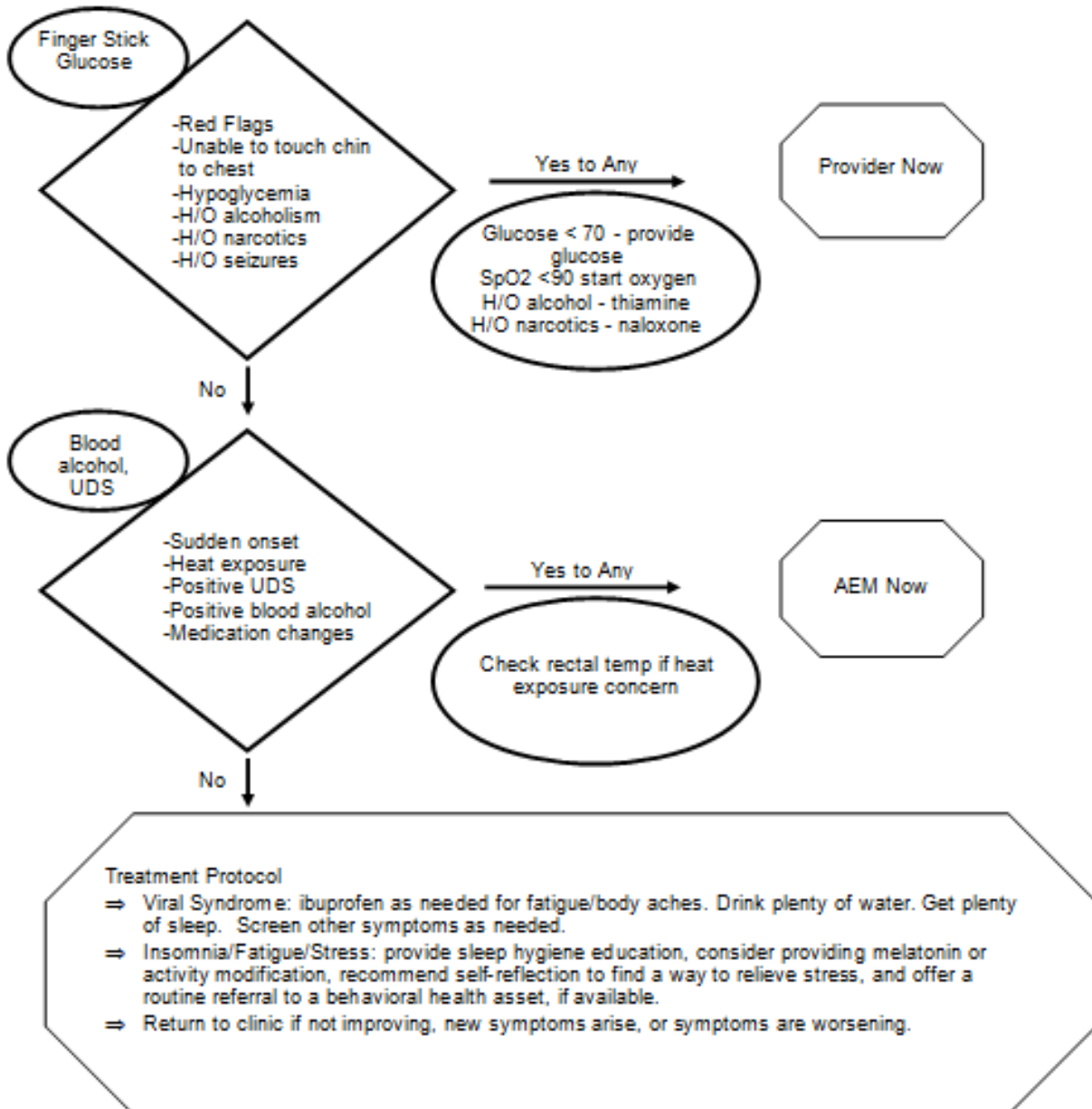
MCP for viral syndrome. Viral syndrome can present as fatigue described as drowsiness. It is a global feeling often associated with other symptoms and muscle aches. Treat with ibuprofen as needed for fatigue/body aches. Treat other symptoms in accordance with the corresponding minor-care protocol.

MCP for sleep problems. Sleep issues can present as fatigue described as weakness. It can be a manifestation of depression or stress among other things. Provide education on sleep hygiene, consider providing diphenhydramine or melatonin nightly for three nights, consider activity modification, discuss stress management, and offer a routine referral to behavioral health asset for counseling and treatment.

F-4: In accordance with MEDCOM Regulation 40-50		
Obtain Blood Glucose Levels	pg.69	(2)(f)
Provide Oxygen	pg.69	(2)(h)
Obtain Laboratory Specimens	pg.69-70	(2)(k)
F-4: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 15: Primary Care	Operate a Glucometer	081-833-0257
Subject Area 4: Airway Management	Administer Oxygen	081-833-0158

DROWSINESS/CONFUSION, F-4

Partial Differential Diagnosis Hypoglycemia Hypotension Hypoxia Concussion Infection Intoxication	RED FLAGS - Abnormal Vital Signs - Altered Mental Status - Focal Neurological Deficit - Recent Trauma	Activity Modification: - Allow for 8 Hours of uninterrupted sleep in any given 24 hour period
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DEPRESSION/NERVOUSNESS/ANXIETY/TENSION, F-5

The terms “depression, nervousness, anxiety, tension” and complaints of “nerves” or “being upset” may all be used by Soldiers to describe problems with mood. Complaints such as these are often due to situational or behavioral health factors, but may also be due to a physical condition. Everyone experiences emotional distress from time to time. However, when symptoms become continuous or interfere with daily functioning, or when suicidal or homicidal thoughts or self-harm are reported, the complaint must be taken seriously and further evaluated.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “provider now.” These can be signs of significant underlying medical or serious behavioral health problems.

DP 1: Ask the following questions: In the past month, have you wished you were dead or wished you could go to sleep and not wake up? Have you had any thoughts about killing yourself? If YES to the second question, ask: Have you thought of how you might do this? Have you started to work out or have worked out the details of how to kill yourself? Do you have any intention of acting on these thoughts of killing yourself? Remain calm. Express concern and do not be dismissive. Do not be judgmental or argumentative. If YES to questions about suicidality, do not leave the Soldier alone. Remove means of self-harm. Do not leave the Soldier waiting alone for a long time in a busy waiting room, as this may increase the Soldier's distress. Be aware that abnormal vital signs and/or anxiety or depression symptoms may represent an underlying medical issue.

DP 2: Ask the following questions for a depression screen: Over the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless? Over the past 2 weeks, have you often been bothered by having little interest or pleasure in doing things? In addition to other situational, mental health, or medical causes, emotional distress may accompany injury and/or chronic pain and may merit a referral to behavioral health services. Ask Soldier how he or she is coping with the injury and/or pain. Other indicators of emotional distress may include disheveled appearance or poor hygiene, reported change in work performance, and risk-taking behavior. Obtain a list of all medications and the amounts taken to provide to the AEM. Taking significantly more of a medication than the prescribed amount may represent a suicidal gesture and should be inquired about if reported. If the Soldier was accompanied to the screening area by an escort, it may be due to high risk behavior or safety concerns. Inquire as to reason for escort, asking escort if necessary.

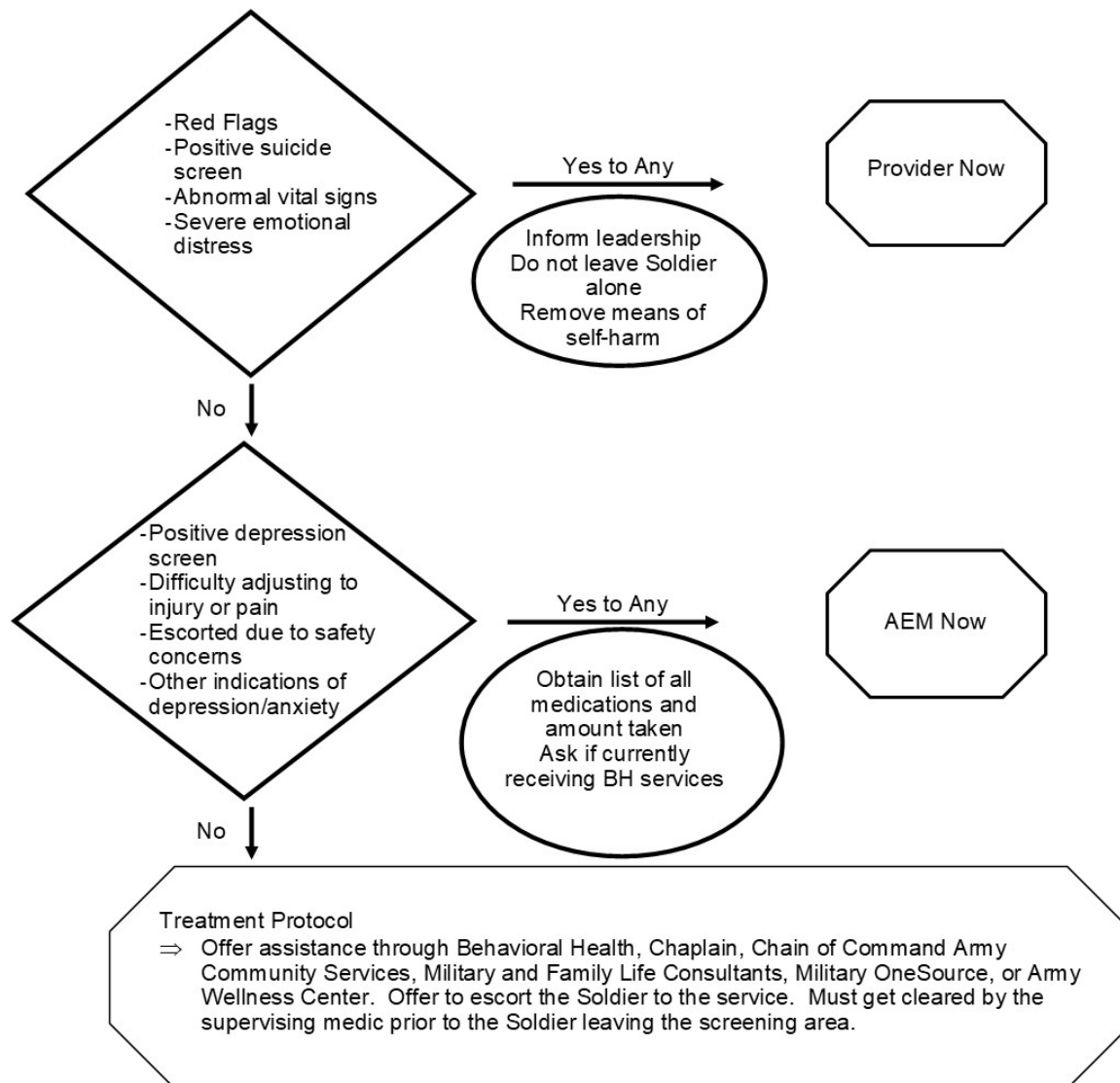
TREATMENT PROTOCOL, F-5

MCP for decreased mood. Soldiers that are experiencing mood symptoms that are mild in nature and not associated with other symptoms or impairment should be offered assistance. As always, remain calm, express concern for the Soldier, and do not be judgmental or argumentative. Educate the Soldier on the many resources that are available in your area, to include: *Behavioral Health, Chaplaincy, Army Community Services, Chain of Command, Military and Family Life Consultants, Military OneSource, and Army Wellness Center.* Offer to walk the Soldier to the resource that they prefer. Do not allow the Soldier to leave the screening area until they have been cleared by the supervising medic.

F-5: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Provide Treatment for a Behavioral Emergency	081-833-0246

DEPRESSION/NERVOUSNESS/ANXIETY/TENSION, F-5

Partial Differential Diagnosis Depression Anxiety Hypoxia Hypo/hyperthyroidism Substance intoxication or withdrawal	RED FLAGS - Homicidal Intent or Attempt - Suicide Intent or Attempt - Self-Injury - Altered Mental Status	Activity Modification: - Escort to Behavioral Health or Emergency Room
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MINOR TRAUMATIC BRAIN INJURY, F-6

A minor traumatic brain injury (mTBI) or concussion is an injury to the brain that may result after blunt force, an acceleration/deceleration head injury (whiplash), or exposure to a blast wave (close contact or prolonged duration such as a firing range). In addition, mild TBIs are defined by at least one of the following clinical signs immediately following the event: alteration of consciousness lasting <24 hours, loss of consciousness <30 minutes, or post-traumatic amnesia <24 hours. CT scans are not indicated for most patients with concussion, but if obtained, the results are typically normal.

Red Flags. If the Soldier presents with any red flag, immediately disposition the Soldier as “Provider Now” as these can be signs of medical emergencies.

DP 1: All Soldiers with a possible mTBI should be screened using the *Military Acute Concussion Evaluation*, version 2 (MACE 2) exam and results should be documented on the Soldier’s medical record. The MACE 2 assesses for red flags and the five predominate concussion sub-types (vestibular, oculomotor, headache/migraine, anxiety/mood, and cognitive).

Presence of the following observable signs are suggestive of a concussion and prompt thorough evaluation: (1) lying motionless on the ground, (2) slow to get up after a direct or indirect blow to the head, (3) disorientation, confusion or inability to respond appropriately to questions, (4) blank or vacant look, (5) balance difficulties, stumbling, or slow labored movements, and (6) facial injury after head trauma.

A positive initial screening on the MACE 2 indicates a concussive injury and often presents as alteration of consciousness (seeing stars, dazed, confused), loss of consciousness, or amnesia (trouble remembering the event). Positive screening with the following are recommended for a CT scan of the head: deteriorating level of consciousness, double vision, increased restlessness, combative or agitated behavior, severe or worsening headache, mental status (GCS<15), suspected skull fracture, sign of basilar skull fracture (hemotympanum, raccoon eyes, Battle sign, oto-/rhinorrhea), 2+ episodes of vomiting, amnesia for 30+ minutes before incident, neurologic deficit, seizure, severe incident (hit by motor vehicle, ejection from vehicle, fall >3 feet/ >5 stairs), or on an anticoagulant.

The MACE 2 encompasses the following key areas: (1) concussion screening, (2) history questions (related to anxiety, migraine, and cervicogenic assessment), and (3) neurological, cognitive, and vestibular/oculomotor assessments. The neurological assessment includes speech fluency, word finding, single leg stance, tandem gait, pronator strength and eye tracking. The cognitive section includes scored evaluations of orientation and immediate and delayed recall. The vestibular/ocular-motor screening (VOMS) is a symptom-provoking exam that is necessary to detect patients at risk for delayed recovery due to oculomotor and vestibular deficits. Symptoms assessed are headache, dizziness, nausea, and foginess.

DP 2: A MACE 2 cognitive score less than or equal to 25, any abnormality on the neurological exam, any abnormality on the VOMS exam, presence of one or more symptoms, observed loss or alteration of consciousness, or a history of TBIs require additional evaluation and treatment.

TREATMENT PROTOCOL, F-6

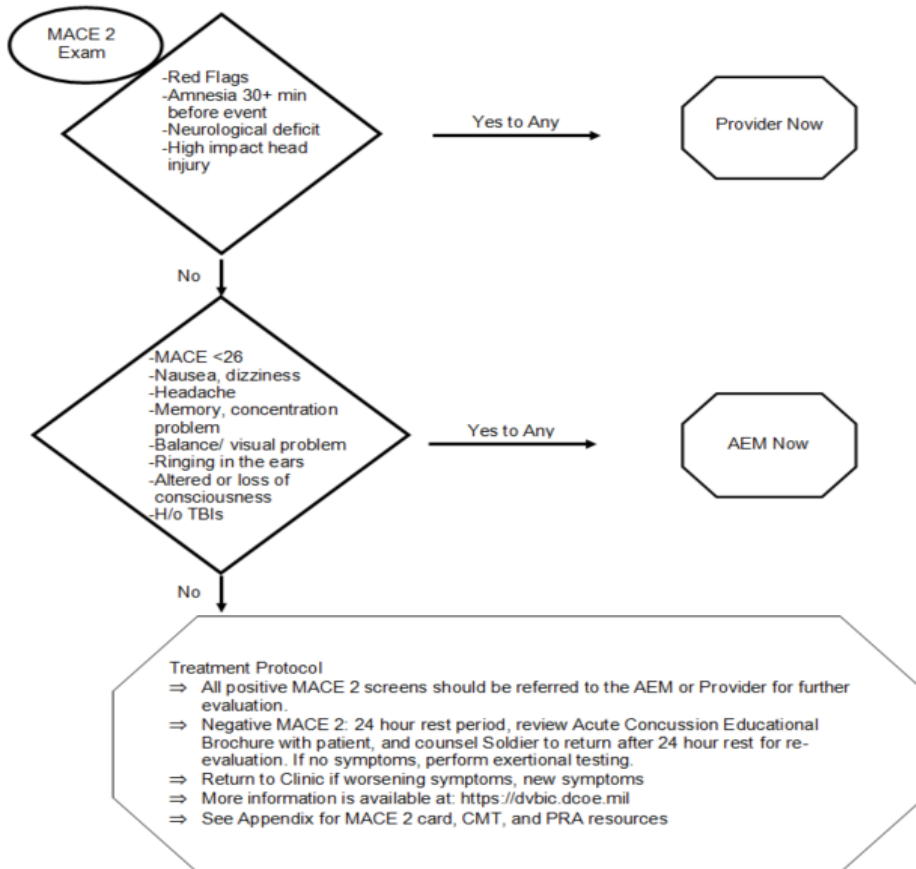
MCP for mTBI. MACE 2 screening that does not identify a concussion (screens negative) can be managed with reviewing the *Acute Concussion Educational Brochure* with Soldier, a mandatory 24 hour rest period followed by a re-evaluation after the 24 hour rest period prior to the Soldier returning to duty. Re-evaluation should include exertional testing if the Soldier is still asymptomatic. Exertional testing increases the cardiac output (blood pressure and heart rate) which can worsen symptoms by increasing swelling if present. Return to the clinic if symptoms worsen or new symptoms develop. More information is available at <https://dvbic.dcoe.mil>.

Concussion treatment is guided by the results of the symptom cluster assessment generated by the MACE 2. A MACE 2 screening that identifies a concussion (screens positive) should prompt a minimum of 24-hour rest, with follow-up every 24 to 48 hours up to seven days. Additionally, concussions should be managed by initiation of the concussion management tool (CMT) and progressive return to activity (PRA) by a medical provider or other trained medical staff member. Results from the MACE 2 align to specific treatment protocols embedded within the CMT. Rapidly addressing vestibular and oculomotor deficits identified by the MACE 2 and daily evaluation of progress with the PRA will lead to faster recovery. The new MACE 2, CMT and PRA are enclosed in the appendix.

F-6: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform a Military Acute Concussion Evaluation 2 (MACE 2) Screening for mild Traumatic Brain Injury	081-833-0247

MILD TRAUMATIC BRAIN INJURY, F-6

<p>Partial Differential Diagnosis</p> <ul style="list-style-type: none"> Headache/migraine Concussion Intracerebral Hemorrhage Anxiety Stroke Spinal cord injury Seizure Dehydration 	<p>RED FLAGS</p> <ul style="list-style-type: none"> - Deteriorating Level of Consciousness - Double Vision -Increased Restlessness, combative or agitated behavior - Repeat vomiting -Positive result from structural brain injury detection device (if available) - Seizure -Weakness or tingling in arms or legs -Severe or worsening headache - Abnormal Neuro Exam - Battle sign, Raccoon eyes -Suspected skull fracture -Anticoagulant use 	<p>Activity Modification:</p> <p>Use the Concussion Management Tool (CMT) and associated Progressive Return to Activity (PRA) for specific management</p> <p>A minimum of 24 hour rest, defined as:</p> <ol style="list-style-type: none"> 1. Rest with extremely limited cognitive activity 2. Limit physical activities to those of daily living and extremely light leisure activity 3. Avoid working, exercising, playing video games, studying, or driving 4. Avoid any potentially concussive events 5. Avoid caffeine and alcohol <p>Reassess using the MACE 2 after 24 hours rest</p>
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FATIGUE, G-1

Fatigue is a state of increased demand/stress on the body or decreased efficiency.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of medical emergencies.

DP 1. While fatigue is often not caused by a specific disease, it may be a presenting symptom of a potentially serious condition. Depression may only present as fatigue. Decreased libido could be a sign of an adrenal/pituitary issue. Weight change could represent hypo/hyperthyroidism. Menorrhagia often results in anemia. Snoring can be a sign of sleep apnea. USPSTF Screening/PHA is to look at age appropriate cancer and cardiovascular screening. Infections, inflammation, liver/kidney disease, and medication/drug use can also cause fatigue.

DP 2. If the Soldier has other specific complaints or symptoms, the Soldier should be evaluated for that complaint. Otherwise, the minor-care protocol is appropriate.

TREATMENT PROTOCOL, G-1

MCP for fatigue. Advise the Soldier that vitamins are rarely helpful, that “pep pills” do not work (the rebound usually makes the problem worse), and that tranquilizers generally intensify fatigue. Taking a vacation, if possible, or undertaking new activities are often helpful.

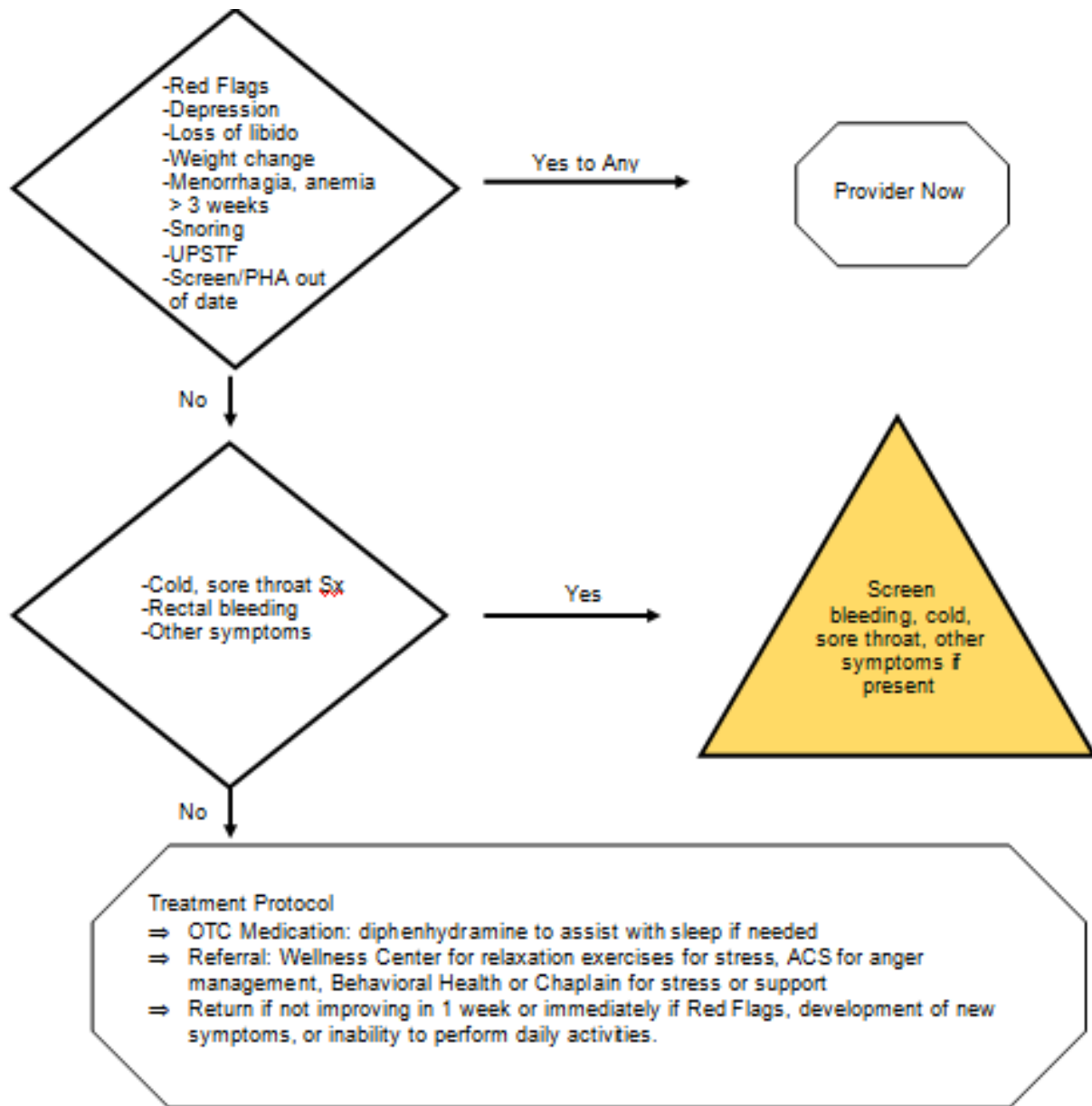
Helpful Actions Include: Identifying potential sources of the fatigue such as work stress, marital discord, lack of rest or sleep (either quantity or quality of sleep), or a poor/not well balanced diet. Provide information on proper sleep hygiene and refer to sleep hygiene course if locally available. If not a suicidal risk (which would require immediate referral) suggest various available options for counseling, including behavioral health, Army community services, and the chaplain. Work on the problem rather than on the symptom.

Seek medical assistance if symptoms worsen, other symptoms develop, fatigue makes normal activities difficult, difficulty staying awake while driving, or not improved within one week.

MCP for sleep problems. Sleep issues can present as fatigue described as weakness. It can be a manifestation of depression or stress among other things. Provide education on sleep hygiene, consider providing diphenhydramine or melatonin nightly for three nights, consider activity modification, discuss stress management, and offer a routine referral to behavioral health asset for counseling and treatment.

FATIGUE, G-1

Partial Differential Diagnosis Sleep Debt Sleep Apnea Anemia Anxiety Disorders Chronic Infection/Inflammation Chronic fatigue syndrome Acute liver failure	RED FLAGS - Suicide Ideation - Homicide Ideation - Shortness of Breath - Stiff Neck - Melena	Activity Modification: -Allow for 8 hours of uninterrupted sleep with a 24 hour period
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FEVER/CHILLS, G-2

Fever/chills are usually associated with an acute illness with other obvious symptoms.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of medical emergencies.

DP 1. If the Soldier's temperature is greater than 100.4°F, has symptoms for more than 48 hours, HIV infection, or immunosuppression, then there is a greater risk of the fever being caused by a bacterial infection. Overseas travel, tick or mosquito bite, animal exposure, and malaria endemic area, increase the risk of a zoonotic or malaria infection. IV drug use increases the risk of endocarditis.

DP 2. Before assuming the Soldier has isolated fever/chills, be sure to ask him/her specifically about other symptoms such as upper respiratory infection symptoms, cough, sore throat, ear pain, diarrhea, dysuria, rash, and muscle aches. If no associated symptoms can be identified, over half of Soldiers' fever will resolve on its own without an underlying issue being identified.

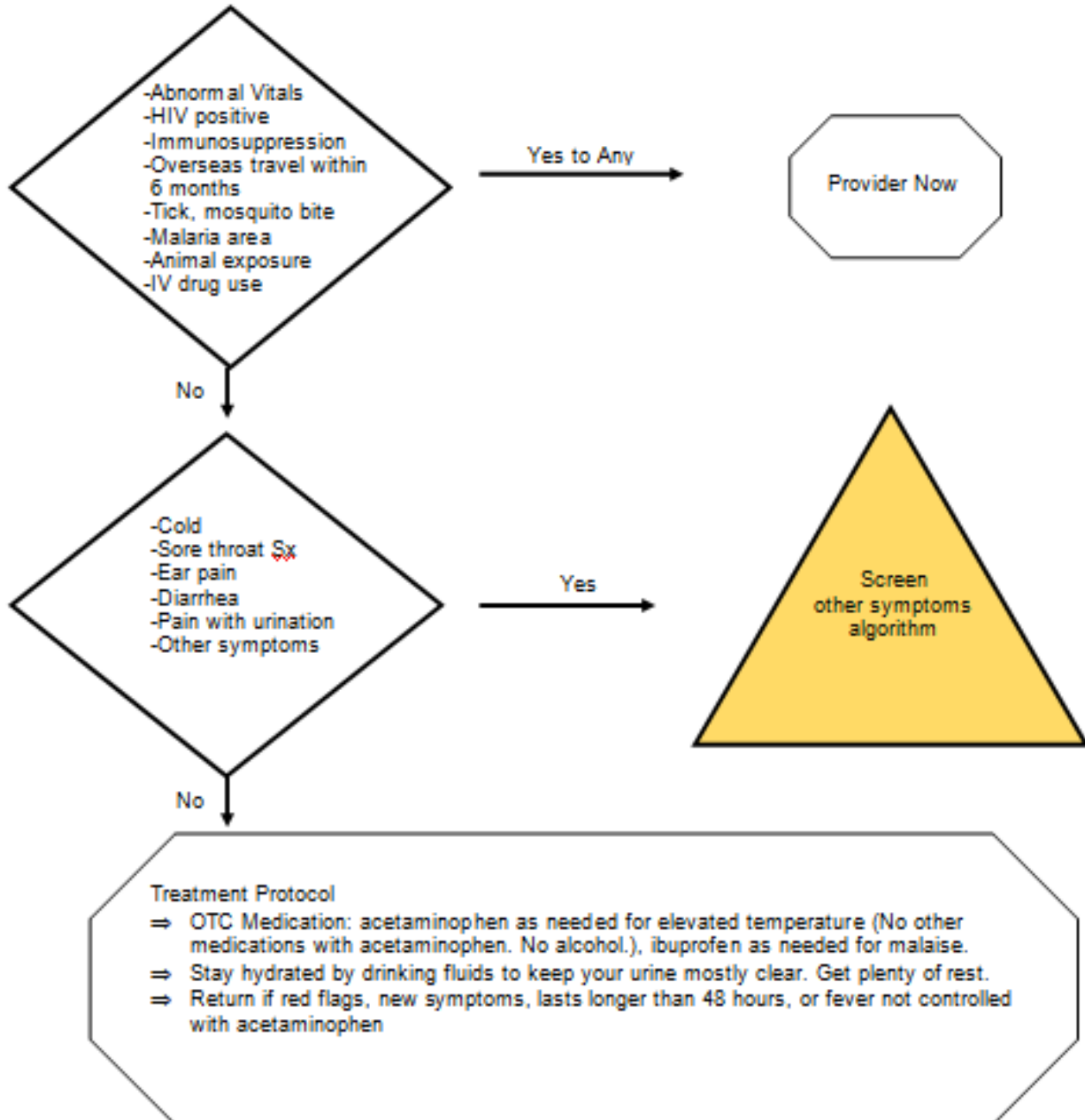
TREATMENT PROTOCOL, G-2

MCP for elevated temperature. Instruct the Soldier to stay well hydrated and get plenty of rest. He or she should drink fluids to keep their urine mostly clear and obtain at least eight hours of rest per day. Take acetaminophen as needed for temperature above 98.4°F (No more than eight tablets within 24 hours. No other medications with acetaminophen in them. No alcohol.)

Soldier is contagious while he or she has an elevated temperature. He or she should avoid contact with healthy Soldiers as much as possible. If in training, refer to local SOP. Soldier may need to be placed in quarters. Return for medical assistance if symptoms do not improve with acetaminophen, other symptoms develop, or a fever develops (T > 100.4).

FEVER/CHILLS, G-2

Partial Differential Diagnosis Malaise Cold Symptoms Sore Throat, Ear Pain Heat/Cold Injury Diarrhea Pain with urination	RED FLAGS - Heat Injury - Stiff Neck - Light sensitivity - Pregnant - Seizure - Lightheaded	Activity Modification: For a Fever -Consider Quarters x 24-48 hours (must discuss with supervising privileged provider)
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EYE PAIN/REDNESS/DISCHARGE/ITCHING/INJURY, H-1

Eye pain, redness, discharge, itching, and injury includes trauma to common inflammatory and infectious conditions.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of medical emergencies.

DP 1. Perform an eye exam with visual acuity. Do not perform a fluorescein exam if concerned for an open globe. Cover the eye with an unpadded protective fox shield or cup and discuss with the supervising privileged provider if a potential foreign body. A privileged provider order is required to irrigate the eye except when immediate irrigation is required for a chemical exposure. A white or red layered fluid level over the iris is a sign of a hypopyon or hyphema, respectively, requiring emergent referral. Contact lens, recent eye surgery, and fluorescein uptake increase potential of a serious condition.

DP 2. Thick, yellow or green discharge that continues throughout the day suggests bacterial conjunctivitis. Eye pain, light sensitivity, inability to open or keep the eye open, and foreign body sensation suggests a corneal or intraocular inflammatory process. Fast moving metal or glass slivers from an explosion or welding can penetrate the eye with symptoms that rapidly disappear. A history of a foreign body that is now “getting better” should be screened as a foreign body.

TREATMENT PROTOCOL, H-1

MCP for blepharitis (crusting of the eye in the morning with or without red, swollen eyelids). Treatment is washing of the eyelashes daily with washcloth using warm water and non-tearing baby shampoo, warm compresses, lid massage. Instruct to avoid lotions, creams, make-up to the affected area. RTC if worsening or not improving within one week.

MCP for dry eyes (tearing, blurry vision that clears with blinking, and a gritty sensation). Treatment is artificial tears as needed (prn).

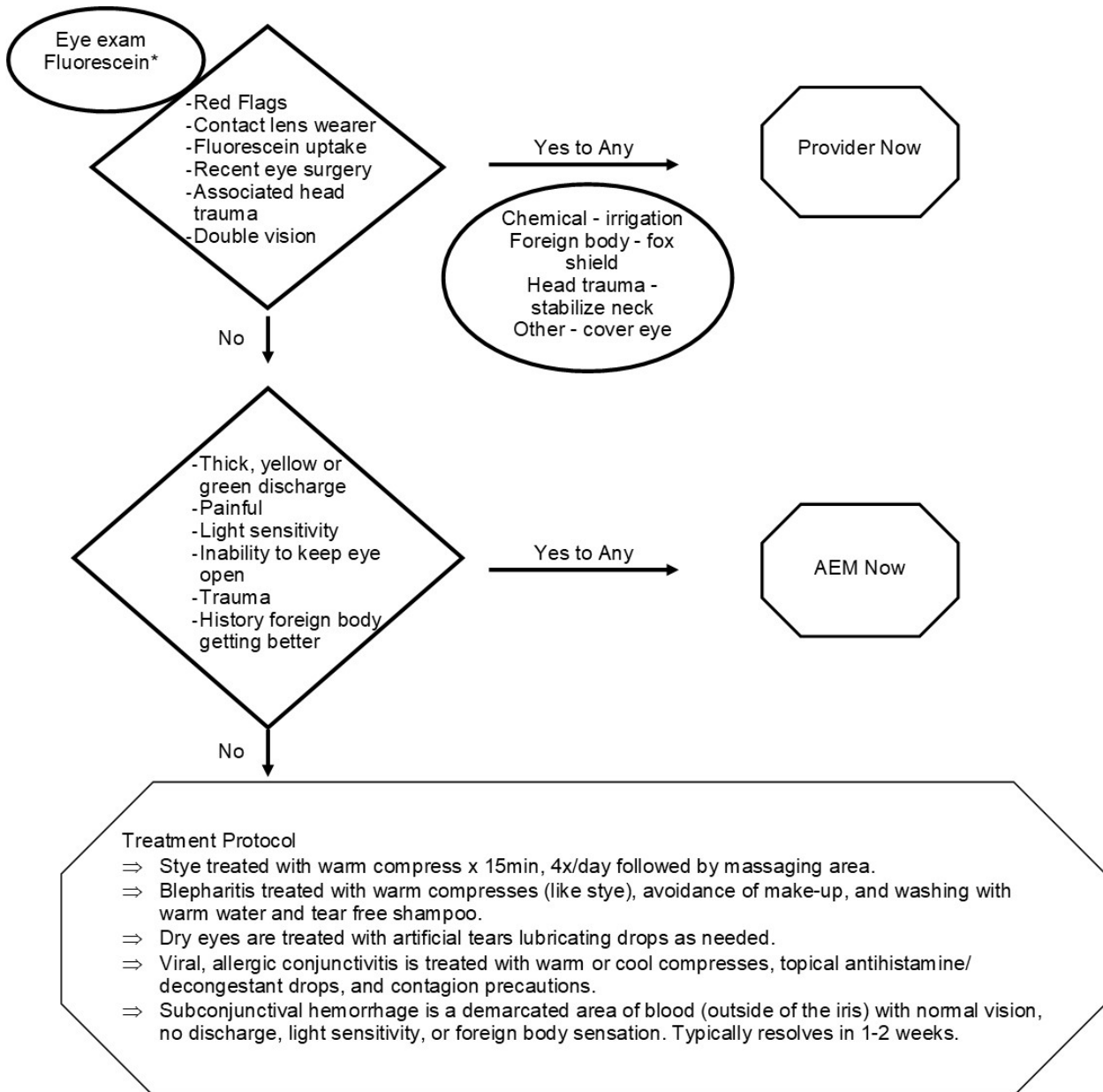
MCP for viral, allergic conjunctivitis (crusting, watery discharge with burning (viral) or itching (allergic)). Viral is highly contagious. Treatment is with warm or cool compresses and topical antihistamine/decongestant drops.

MCP for subconjunctival hemorrhage. Further evaluation is necessary when associated with trauma, is recurrent, or Soldier is on an anticoagulant.

H-1: In accordance with MEDCOM Regulation 40-50		
Administer Ophthalmic Medication	pg.67	(3)(c)
Examines Eye Using Fluorescein Strip	pg.69	(2)(i)
H-1: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 18: Medication Administration	Administer Eye Medications	081-833-0015

EYE PAIN/ REDNESS/DISCHARGE/ITCHING/INJURY, H-1

Partial Differential Diagnosis Blepharitis Allergies Conjunctivitis Corneal Abrasion/Trauma Subconjunctival Hemorrhage Keratitis/Iritis	RED FLAGS - Fixed, Abnormal Pupil - Visual Acuity Change - Observed Foreign Body - Penetration, Rupture - Chemical Exposure - Fluid Level over Iris, Pupil	Activity Modification: None
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*Do not perform fluorescein exam if there is concern for an open globe or ruptured eye.

EYELID PROBLEM, H-2

Eyelid problems include serious effects of trauma to simple conditions of inflammation.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of medical emergencies.

DP 1. Assess for life-threatening injuries (head, neck, airway) before performing an eye exam with visual acuity. Assess for signs of an open globe. Laceration of full thickness of eyelid, with orbital fat prolapse, through lid margin, involving lateral/medial/tear duct/or muscles, or associate with avulsion or malalignment requires referral. Decreased visual acuity and double vision along with pain, fixed pupil, and swelling around the eye are signs of a potential internal eye injury. Orbital compartment syndrome can develop which is a medical emergency requiring immediate treatment.

DP 2. Significant redness and swelling can be signs of cellulitis. Cellulitis is a relatively common complication of a stye. It requires further evaluation and treatment with oral antibiotics. Dermatitis and some systemic diseases can also present with an eyelid rash requiring further evaluation and treatment.

TREATMENT PROTOCOL, H-2

MCP for stye. Presents with redness, tenderness, and swelling of the eyelid. Initial treatment should be a warm compress placed on the area for 15 min four times per day with massage of the area after the warm compress. Return to clinic if becomes significantly painful, redness and swelling spreads, or not improving within one week.

MCP for chalazion. Presents with painless swelling of the eyelid. It is treated the same way as a stye and usually resolves within a couple of weeks.

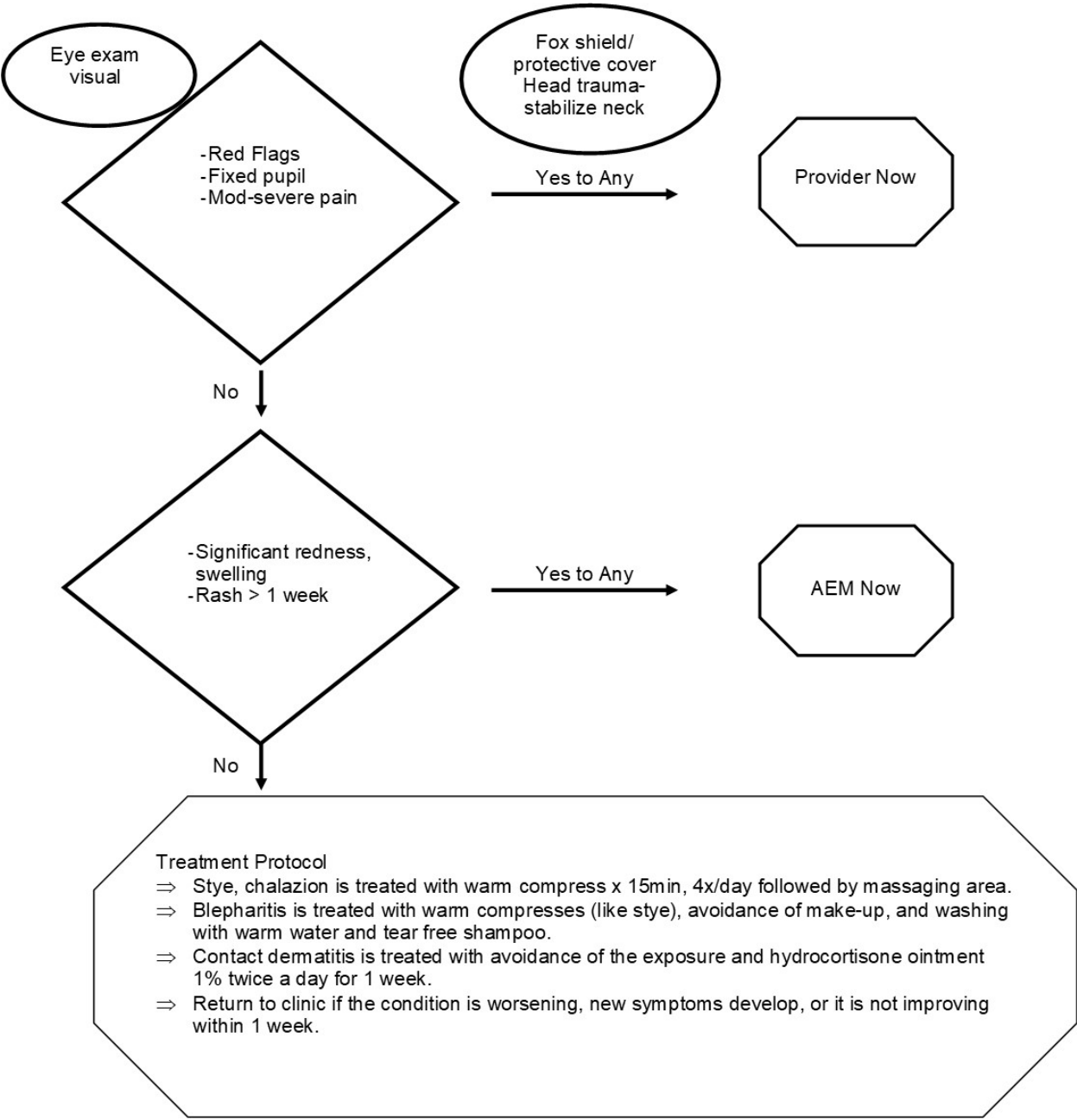
MCP for blepharitis. Presents with bilateral crusting of the eye in the morning and may be associated with red, swollen eyelids, and dry eyes that improve with blinking. Treatment is washing of the eyelashes daily with washcloth using warm water and non-tearing baby shampoo, warm compresses, lid massage. Instruct to avoid lotions, creams, make-up to the affected area. RTC if worsening or not improving within one week.

MCP for contact dermatitis. Skin reaction from an irritant. In a female, make-up is the most common cause. Evaluate for any new exposures, other areas involved. Instruct to avoid the most likely contact/cause and any lotions, creams, or soaps with perfumes, hair dyes, new shampoos, and eye make-up. Use hydrocortisone cream with precautions to avoid getting it in the eye.

H-2: In accordance with MEDCOM Regulation 40-50		
Administer Ophthalmic Medication	pg.67	(3)(c)
H-2: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 18: Medication Administration	Administer Eye Medications	081-833-0015

EYELID PROBLEM, H-2

Partial Differential Diagnosis Stye, Blepharitis Dermatitis Infection Eyelid laceration	RED FLAGS - Open Globe - High Risk Laceration - Decreased Visual Acuity - Double Vision	Activity Modification: None
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DECREASED VISION, SEEING SPOTS, REQUEST FOR GLASSES, H-3

Decreased vision can mean that images are less distinct or that a portion of the visual field is “blacked out.” The Soldier may refer to the spots as stars, flashes, or floaters.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of medical emergencies.

DP 1. Perform an eye exam with visual acuity. Decreased visual acuity following trauma may indicate a serious injury that requires immediate treatment. Retinal detachment is often preceded by flashes of light, new floaters, and black spots, these symptoms should prompt a dilated retinal exam as soon as possible by an eye care provider. A foreign body seen on exam should not be removed. Cover the eye with a protective fox shield or cup and discuss with the supervising privileged provider. A privileged provider order is necessary prior to irrigation of a foreign body except when immediate irrigation is required for a chemical exposure. A white or red layered fluid level over the iris is a sign of a hypopyon or hyphema, respectively, and requires emergent referral. If the decreased vision involves a distinct part of the visual field which includes a black spot that moves with your eye, the cause may be serious.

DP 2. Wearing contacts increases the risk of keratitis and corneal abrasion. Fluorescein exam is the next step to evaluate for these causes. Visual acuity of contact wearer should be performed with and without glasses to evaluate for a change in vision not related to the contacts. Acute onset and pain are signs of a more concerning cause than the need for glasses. Migraine can be associated with temporary decreased vision or seeing spots prior to a headache (an aura).

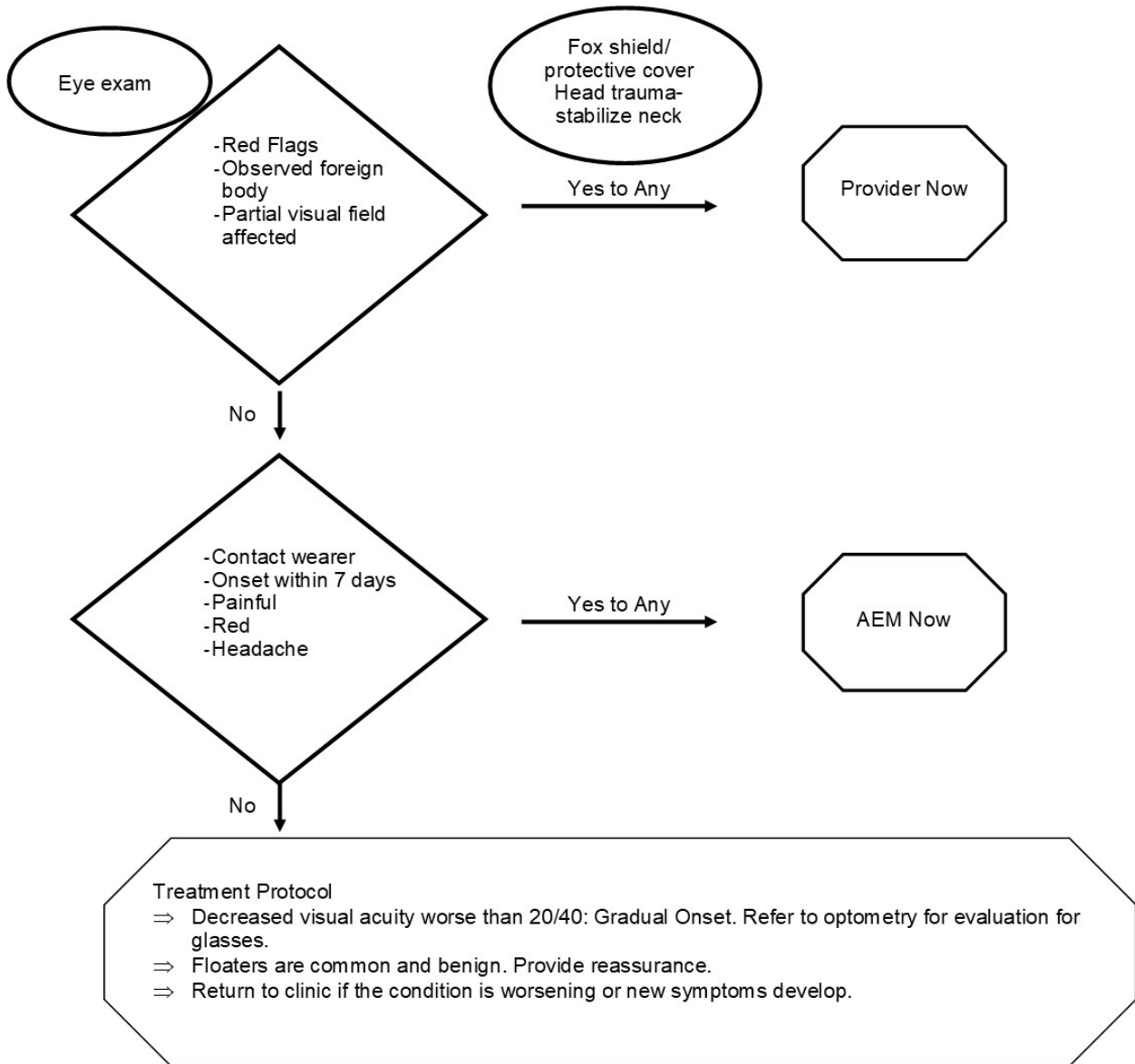
TREATMENT PROTOCOL, H-3

MCP for decreased vision. Visual acuity worse than 20/40 requires a referral to optometry for evaluation for glasses. Worsening of the vision is gradual and often occurs in both eyes. Noticing the issue may occur with a specific activity like trying to read a sign, seeing a target at the range, or Soldier may present requesting an evaluation or been screened during a yearly readiness screening. (**Note:** protective mask inserts are not usually provided to personnel with uncorrected vision of 20/40 or better). Floaters are clumps of material in the gel-like substance in the back of your eye. They are common, benign and move around in your field of vision. They are not fixed to a particular location in the field of view or significantly obstruct the field of view.

H-3: In accordance with MEDCOM Regulation 40-506		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
H-3: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform Visual Acuity Testing	081-833-0193
Subject Area 3: Trauma Treatment	Apply a Cervical Collar	081-833-0177

DECREASED VISION, SEEING SPOTS, REQUEST FOR GLASSES, H-3

Partial Differential Diagnosis Trauma Migraine Hemorrhage Infection Ischemia, Stroke	RED FLAGS - Trauma - Recent Surgery - Chemical Exposure - Fluid Level over Iris, Pupil - Neurologic Deficits	Activity Modification: None
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SEEING DOUBLE (DIPLOPIA), H-4

Double vision means seeing two images of a single object.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of medical emergencies.

DP 1. Assess for potential life-threatening injuries (head, neck, and airway) before accessing for vision issues. If the double vision is related to a recent trauma to the head, neck, or back, then it may represent a serious injury to the brain. Neurologic deficits (trouble walking, talking) can indicate a serious problem requiring immediate evaluation.

DP 2. Cover one of the patient’s eyes and then the other, assessing whether the double vision persists or not. If double vision continues despite having one eye shut or if double vision is a new issue, the Soldier will need to be referred to an eye care provider (ophthalmologist or optometrist).

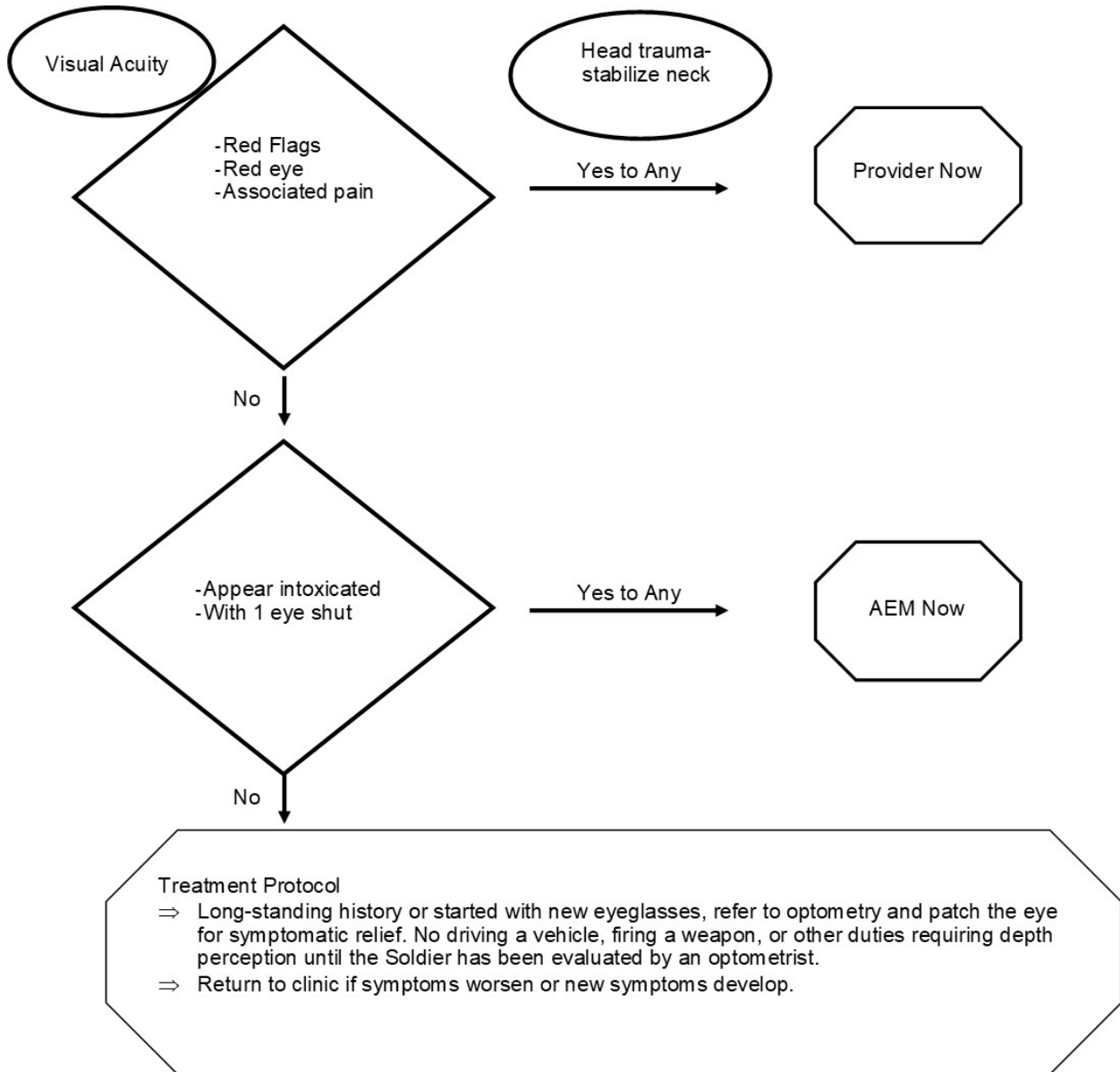
TREATMENT PROTOCOL, H-4

MCP for seeing double. A long-standing history of double vision or double vision caused by new eyeglasses may well indicate a need for evaluation of the eyeglass prescription. The Soldier should be given an appointment at the optometry clinic. Soldier should not drive a vehicle, fire a weapon, or perform other duties requiring depth perception.

H-4: In accordance with MEDCOM Regulation 40-50		
Initial Management of Fractures/Spinal Injury	pg.69	(2)(d)
H-4: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Perform Visual Acuity Testing	081-833-0193
Subject Area 3: Trauma Treatment	Apply a Cervical Collar	081-833-0177

SEEING DOUBLE (DIPLOPIA), H-4

Partial Differential Diagnosis Intoxication Prescription Eyeglasses Muscle Weakness Trauma	RED FLAGS - Trauma - Neurologic Deficits	Activity Modification: - No Driving - No Firing Weapon - No Duties Requiring Depth Perception
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BREAST PROBLEMS, I-1

Breast pain can represent musculoskeletal pain, cyclic pain, or pain associated with inflammation or infection. It is rarely associated with cancer.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be an indication of significant underlying medical problems.

DP 1: Skin changes, mass, or bloody nipple discharge are concerning symptoms that require further evaluation and imaging. Red, swollen breast can represent mastitis or an abscess that requires further evaluation and treatment.

DP 2: Testosterone supplementation in exercise supplements can result in enlargement of breast tissue under the nipple. Enlarged breast tissue can be painful, especially when wearing body armor, further evaluation and counseling are warranted. Nursing mothers often have problems with cracked or infected nipples or have difficulty when the child is weaned, but further examination is required to rule out more concerning issues. Pain without other concerns that is not related to breastfeeding weaning, exercise, or cyclical pain with menstrual cycle requires further evaluation and may require imaging.

TREATMENT PROTOCOL, I-1

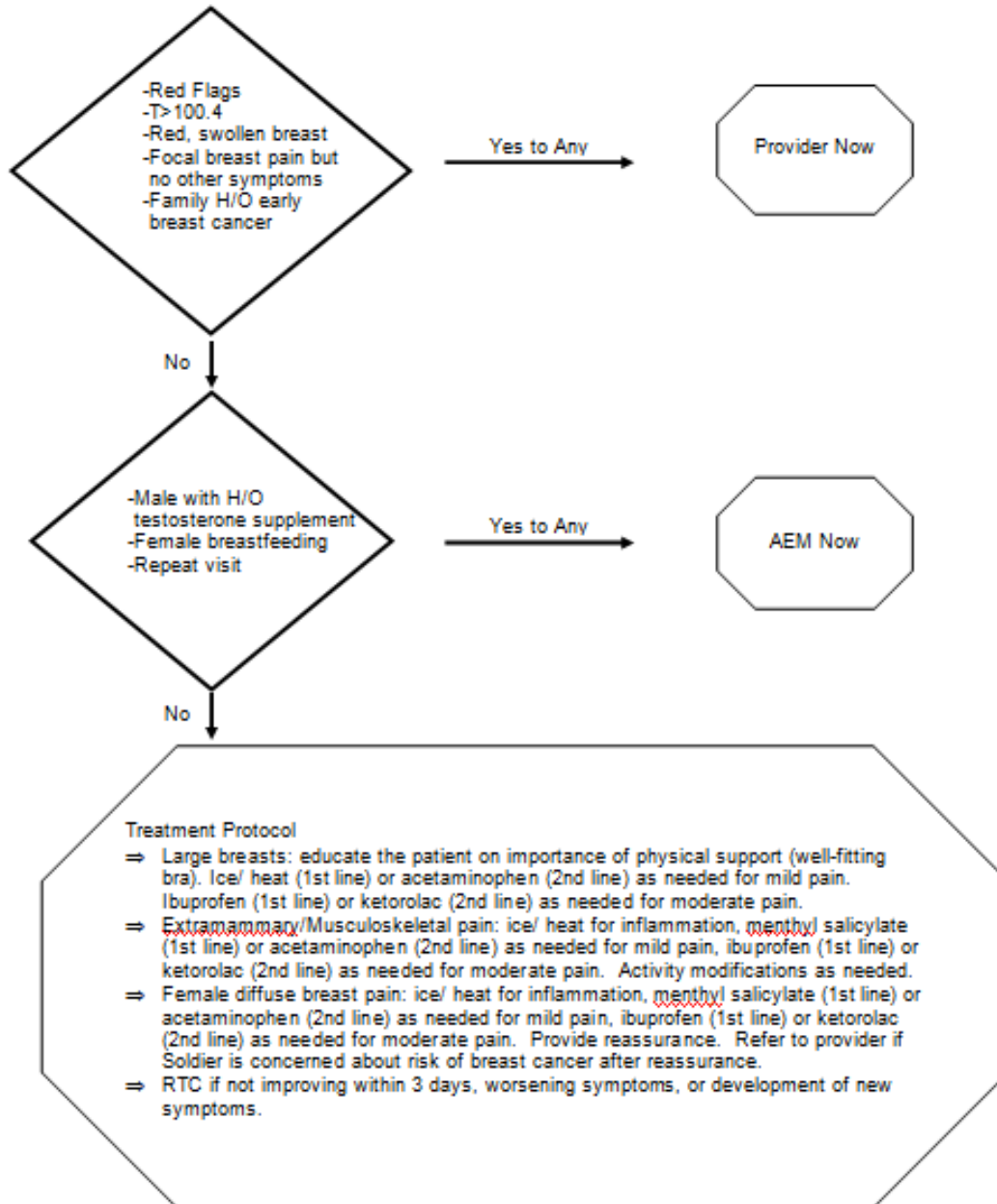
MCP for breast pain. Women with a large amount of breast tissue can have discomfort associated with stretching of Cooper’s ligaments. It can be associated with shoulder, back, or neck pain and made worse with exercise. Educate the Soldier on the importance of supportive undergarments, ice compress/heat compress for inflammation, acetaminophen as needed for mild pain, and ibuprofen (1st line) or ketorolac (2nd line) as needed for moderate pain.

MCP for chest extramammary/musculoskeletal pain. Related to the chest wall and not the breast tissue. Ice/ heat compresses as needed for inflammation. Medication: mentyl salicylate (1st line) or acetaminophen (2nd line) as needed for mild pain, and ibuprofen (1st line) or ketorolac (2nd line) as needed for moderate pain. Activity modifications should be considered as appropriate.

MCP for diffuse breast pain. Diffuse breast pain is unlikely to be related to cancer. Provide reassurance. If the Soldier is concerned about the possibility of breast cancer after reassurance, refer to provider for consideration of an imaging study to provide reassurance. Treat discomfort with ice/heat (1st line) or acetaminophen (2nd line) as needed for mild pain and ibuprofen (1st line) or ketorolac (2nd line) as needed for moderate pain.

BREAST PROBLEMS, I-1

Partial Differential Diagnosis Cyclical Breast Pain Musculoskeletal Issue Large Breasts Mastitis, Abscess Cancer	RED FLAGS - Skin Changes - Mass - Bloody Nipple Discharge	Activity Modification: - No running, jumping, rucking - Walk at own pace/ distance - May lift, carry, push up to 25 lbs
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SUSPECTS PREGNANCY, I-2

Women who believe that their menstrual cycles are late should be evaluated with a pregnancy test. Urine human chorionic gonadotrophin (hCG) tests have improved over the years and provide results much quicker than in the past. A urine hCG obtained greater than seven to eight days after conception should be positive.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” They can be signs of significant underlying medical problems.

DP 1: Check a urine hCG. If the urine hCG is negative, confirm negative with a serum hCG. Positive hCG with pelvic pain or history of a prior ectopic pregnancy increases the possibility of an ectopic pregnancy. Vaginal bleeding suggests a possible miscarriage or complication of pregnancy.

DP 2: Refer Soldiers with a positive pregnancy test to the AEM. The Soldier will need to receive initial pregnancy counseling that includes medications and foods to avoid, importance of a daily prenatal vitamin, avoidance of alcohol, pregnancy profile, and referral to obstetrics-gynecology clinic. These services are also sometimes provided by the clinic nurse depending on local protocol.

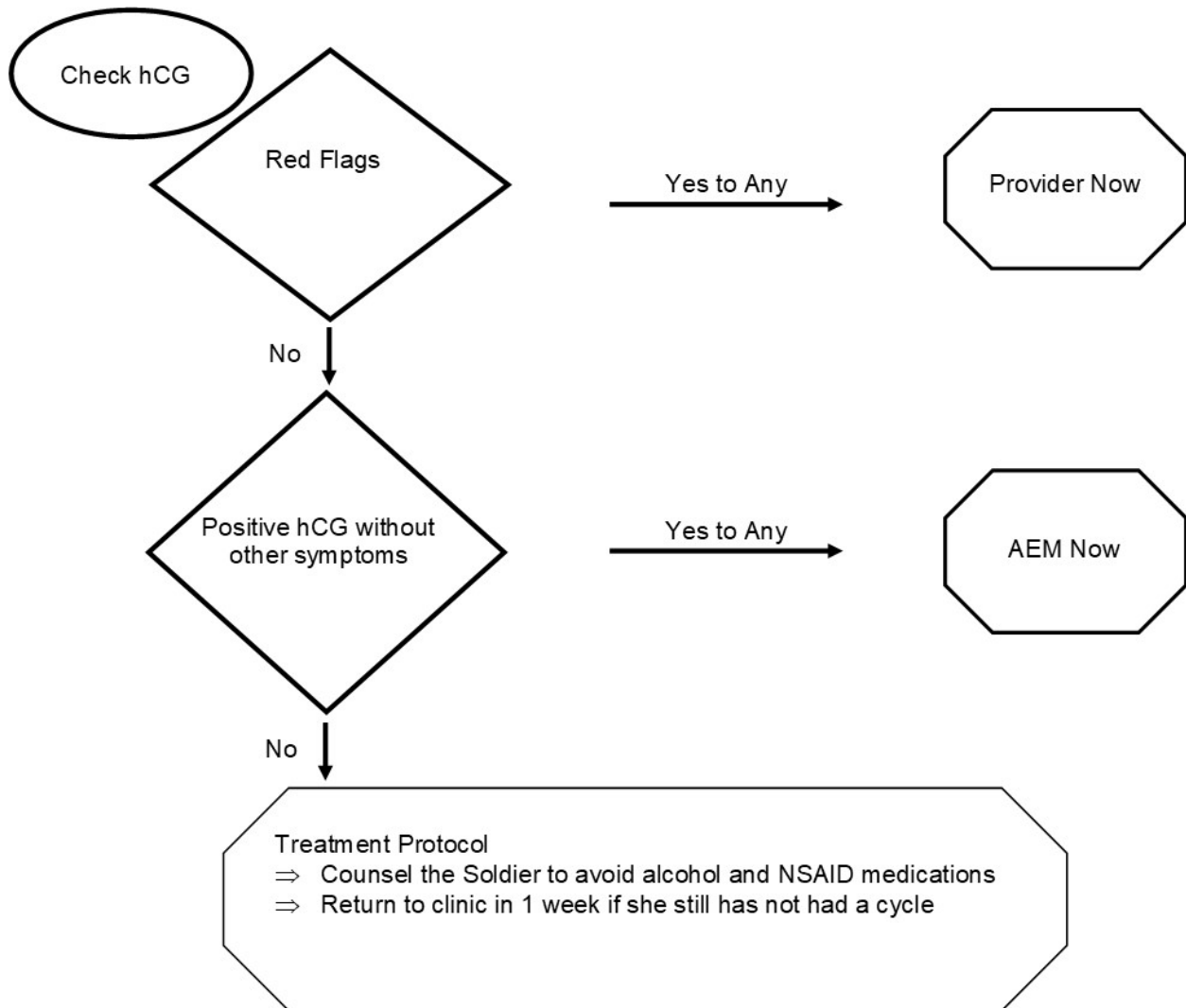
TREATMENT PROTOCOL, I-2

There are multiple causes of a late cycle that are unrelated to pregnancy to include birth control medications, increasing exercise regimen, and stress. Average menstrual cycle is 28 days but can range from 24 to 38 days. Instruct the Soldier to avoid alcohol and NSAID medications (to include Ibuprofen, naproxen, or ketorolac). Return to the clinic in one week if she still has not had a cycle.

I-2: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg.69-70	(2)(k)

SUSPECTS PREGNANCY, I-2

Partial Differential Diagnosis Irregular Menstrual Cycle Pregnancy	RED FLAGS - Positive hCG AND - Pelvic Pain - H/O Ectopic Pregnancy - Vaginal Bleeding	Activity Modification: None
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MENSTRUAL PROBLEMS, VAGINAL BLEEDING, I-3

This protocol is meant to cover menstrual difficulties and vaginal bleeding. If the problems are missed periods (possible pregnancy), vaginal discharge, or abdominal pain, screen according to the appropriate protocol.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: If due to sexual assault, immediately notify the supervising privileged provider. Do not leave the victim alone. Ask if she would prefer a female medic/privileged provider if one is available. If bleeding is over one week late or the previous bleeding was spotting, it could represent a pregnancy. Bleeding during pregnancy (positive hCG) can represent a miscarriage or complication of pregnancy and needs to be seen ASAP. Non-midline pelvic pain and pain with intercourse are signs of pelvic inflammatory disease. Bleeding after menopause (period of no cycle for 12 months after 45 y/o) needs to be evaluated for possible malignancy. Massive Bleeding needs to be seen immediately.

DP 2: Most common problems are irregular and painful periods. Menstrual pain starting after age 25, progressive worsening of symptoms, and poor relief with Ibuprofen are symptoms of a secondary cause to include adenomyosis, endometriosis, or fibroids. Spotting on Depo-Provera, Nexplanon, or IUD is not uncommon but should be examined further. Menses lasting for over five days, more often than every 21 days or less often than 35 days, or bleeding in between menses is considered abnormal. Soaking a pad or tampon more often than every two hours or interferes with daily activities is considered heavy.

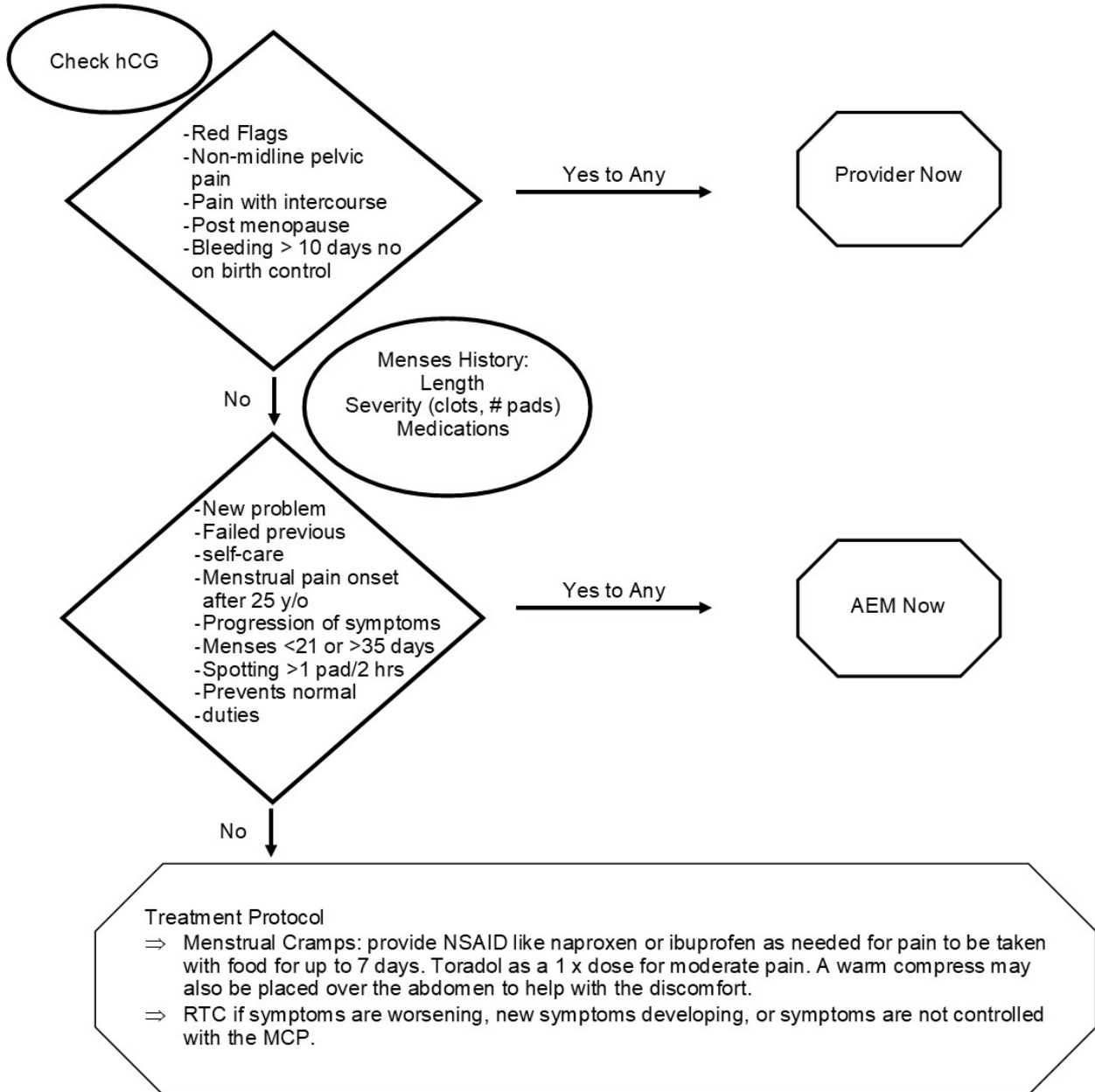
TREATMENT PROTOCOL, I-3

MCP for Painful Menstrual Cycles. Bothersome menstrual cramping (dysmenorrhea) usually lasts about 24 hours. It may be relieved by naproxen or ibuprofen for 5-7 days. Ketorolac can be used on presentation for moderate pain. Seldom is discomfort such that the Soldier is unable to perform normal activities. Give the Soldier symptomatic medication and instructions for use. Instruct the Soldier to return if the symptoms are worsening, new symptoms develop, or the minor-care protocol is not controlling the symptoms such that the problem is preventing performance of normal duties. A privileged provider can evaluate further and may prescribe additional medications to help decrease the symptoms during future menstrual cycles.

I-3: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg.69-70	(2)(k)

MENSTRUAL PROBLEMS, VAGINAL BLEEDING, I-3

Partial Differential Diagnosis Heavy Menstrual Cycle Irregular Menstrual Cycle Birth Control Side Effect Miscarriage Ectopic Pregnancy	RED FLAGS - Sexual Assault - Trauma - Severe Pain - Pregnant	Activity Modification: - Aerobic exercise at own pace/ distance x 3 days - Must have access to restroom every hour
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VAGINAL DISCHARGE, ITCHING, IRRITATION, OR PAIN, I-4

This protocol is meant to cover the majority of vaginal complaints not related to bleeding or a menstrual cycle. If a Soldier has external or vaginal discomfort along with symptoms suggesting a urinary tract infection (frequency, urgency, and internal dysuria), she should be screened as painful urination (dysuria)/frequent urination, E-1.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Fever, non-midline pelvic pain, and pain with intercourse are symptoms of pelvic inflammatory disease, which is a serious infection requiring further evaluation. Vaginal infections and certain medications have a higher risk during pregnancy. Recurrent infections or infections that failed initial therapy require treatment regimens and closer observation. Vaginal discharge, lesion, or ulcer requires an invasive physical exam with laboratory evaluation. If facilities for a speculum physical exam and/or microscopic evaluation are not available and evacuation is not feasible, then treat according to history in minor-care protocol section.

DP 2: Vaginitis may have an atypical presentation. In these situations, a more detailed evaluation is required.

TREATMENT PROTOCOL, I-4

When facilities for a speculum exam and/or microscopic evaluation are not available and evacuation is unfeasible, the Soldier may be treated according the history below.

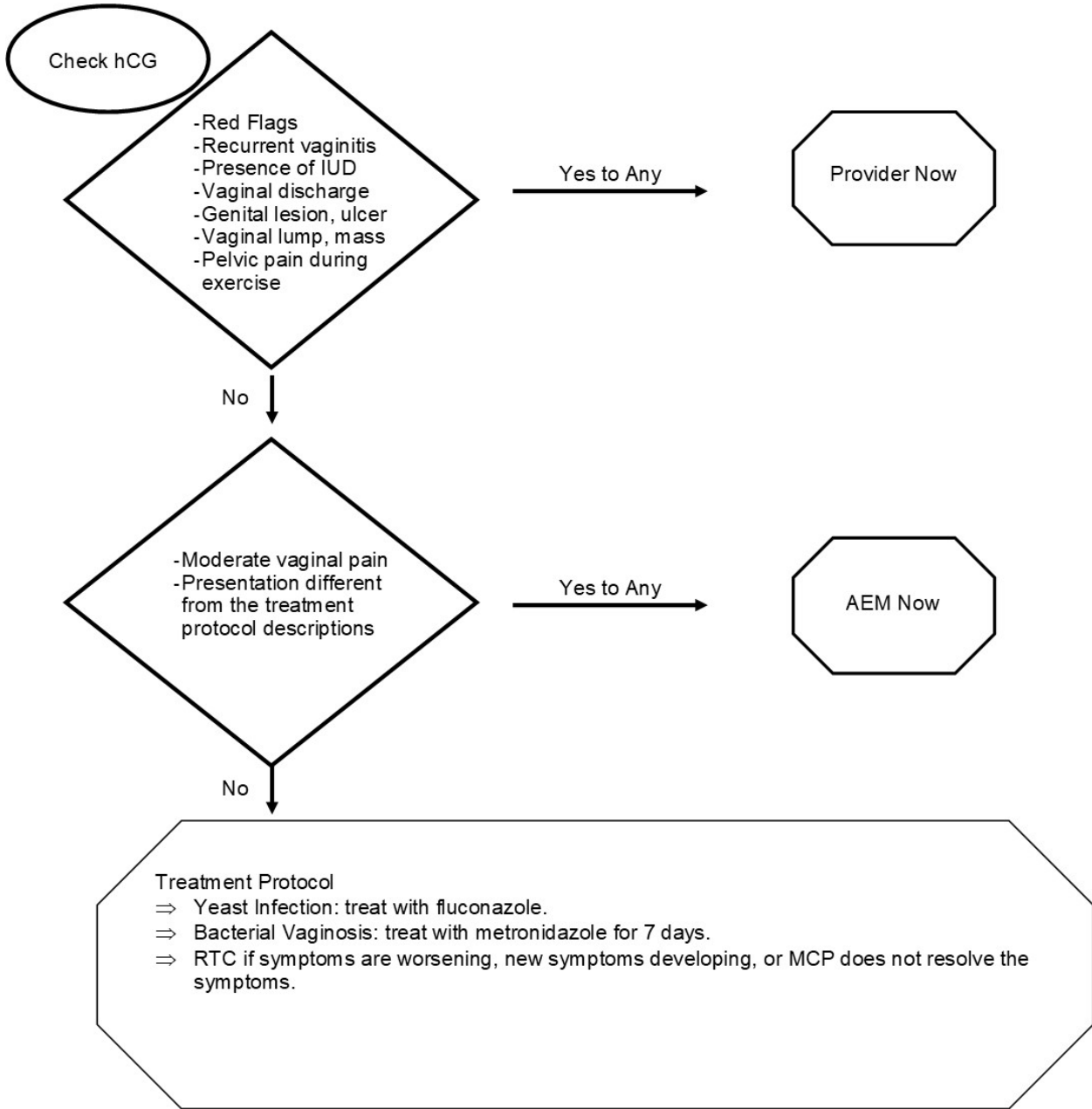
MCP for yeast infection. Presents with a scant amount of thick, white (cottage cheese like) discharge that is usually odorless and may be associated with vulvar itching, soreness, and dysuria. Symptoms are often worse the week before a menstrual cycle. Vaginal pH is typically normal (pH of 4-4.5). Treat with Fluconazole.

MCP for bacterial vaginosis. Presents with a thin, greyish discharge, vaginal pH greater than 4.5, and a fishy smell (prominent when 10% potassium chloride is added to a slide of vaginal discharge) without signs of inflammation. Symptoms are often pronounced during menstrual cycle or after intercourse. Treat with Metronidazole for seven days. Instruct the Soldier to return if the symptoms are worsening, new symptoms develop, or the minor-care protocol does not resolve the symptoms.

I-4: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg.69-70	(2)(k)

VAGINAL DISCHARGE, ITCHING, IRRITATION, OR PAIN, I-4

Partial Differential Diagnosis Bacterial Vaginosis Yeast Infection Trichomonas Pelvic Inflammatory Disease STI	RED FLAGS - Fever - Pregnant - Non-midline Pelvic Pain - Pain with Intercourse	Activity Modification: None
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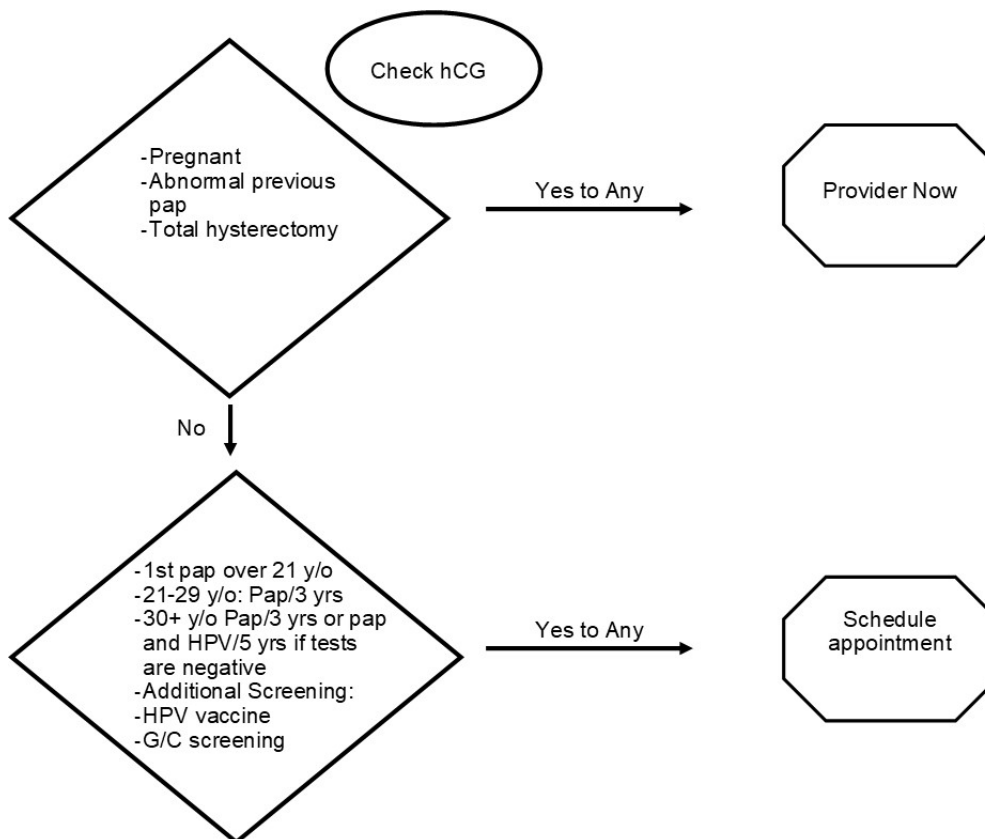
REQUEST FOR PAP OR ROUTINE PELVIC EXAMINATION, I-5

A Pap test is a microscopic examination of cells to detect the presence of pre-cancerous or cancerous process.

DP 1: If the Soldier's menstrual cycle is late, check a pregnancy test. If the Soldier is pregnant, refer to the AEM. Look in lab results for previous pap smears. If there has been an abnormal pap lab result, look for the clinical note that details the plan of care. Determine if the plan was followed and discuss with the AEM to determine care.

DP 2: Confirm the current USPSTF standards. Initial pap smear should be performed starting at 21 years old. From ages 21-29 years old, pap smear should be performed every three years. From age 30 and older, pap smear can be performed every three years or pap smear and HPV testing every five years if both tests are negative. HPV vaccine is recommended up to age 26. G/C screening is recommended yearly for women less than 26 y/o.

I-5: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg.69-70	(2)(k)



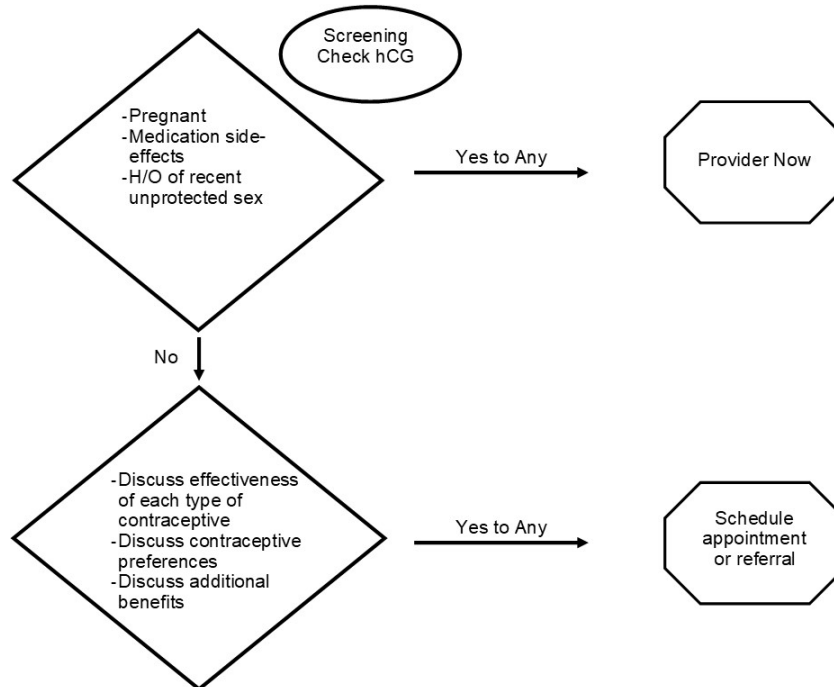
REQUEST FOR INFORMATION ON CONTRACEPTION, I-6

Contraception provides prevention of unintended pregnancy. There are many different types of contraception depending on the Soldier's goals.

DP 1: Determine date of last menstrual cycle. Check a pregnancy test if the Soldier's menstrual cycle is late. Determine history of previous contraceptive use. If the Soldier is having side-effects from her current birth control or has had recent unprotected sex, refer for further evaluation.

DP 2: Long acting contraceptives are the most effective (surgical/permanent, IUD, implantable). Injectable, oral, patch, vaginal ring effectiveness is partially based on consistent, correct use. Condoms and behavioral modification are least effective. Choose the most effective method that the Soldier will be able to use successfully. If male, discuss the permanent nature of the procedure, discuss with AEM, and follow local protocol for referral. Estrogen-progesterone decrease menstrual symptoms, acne, and hirsutism. Progesterone and IUDs decrease menstrual symptoms. Longer term contraception to include injectable types have a risk of irregular bleeding, spotting. Discuss Soldier preferences and history with AEM. Check hCG if requesting Depo-Provera. Schedule accordingly: routine appointment (injectable, oral, patch, ring) or procedural appointment or referral based on supervising privileged provider preferences (implantable, IUD).

I-6: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimens	pg.69-70	(2)(k)



UNKNOWN CAUSE OF SKIN DISORDER/COMPLAINT, J-1

If the cause of the condition is unknown to the Soldier, this first protocol provides the category/ level of care indicated by the Soldier’s symptoms.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Skin rash associated with a medication, fever, or is painful (but not due to a sunburn) has the potential to be very serious. Further evaluation is indicated when it has failed previous treatment or is worsening. Certain anatomical locations present with a higher risk of complications to include the face, genitals area, or inhibiting a joint function.

DP 2: Change in a lesion or oozing of fluids require further evaluation. Skin lesions that have been present for over 4 weeks may represent a symptom of a systemic condition.

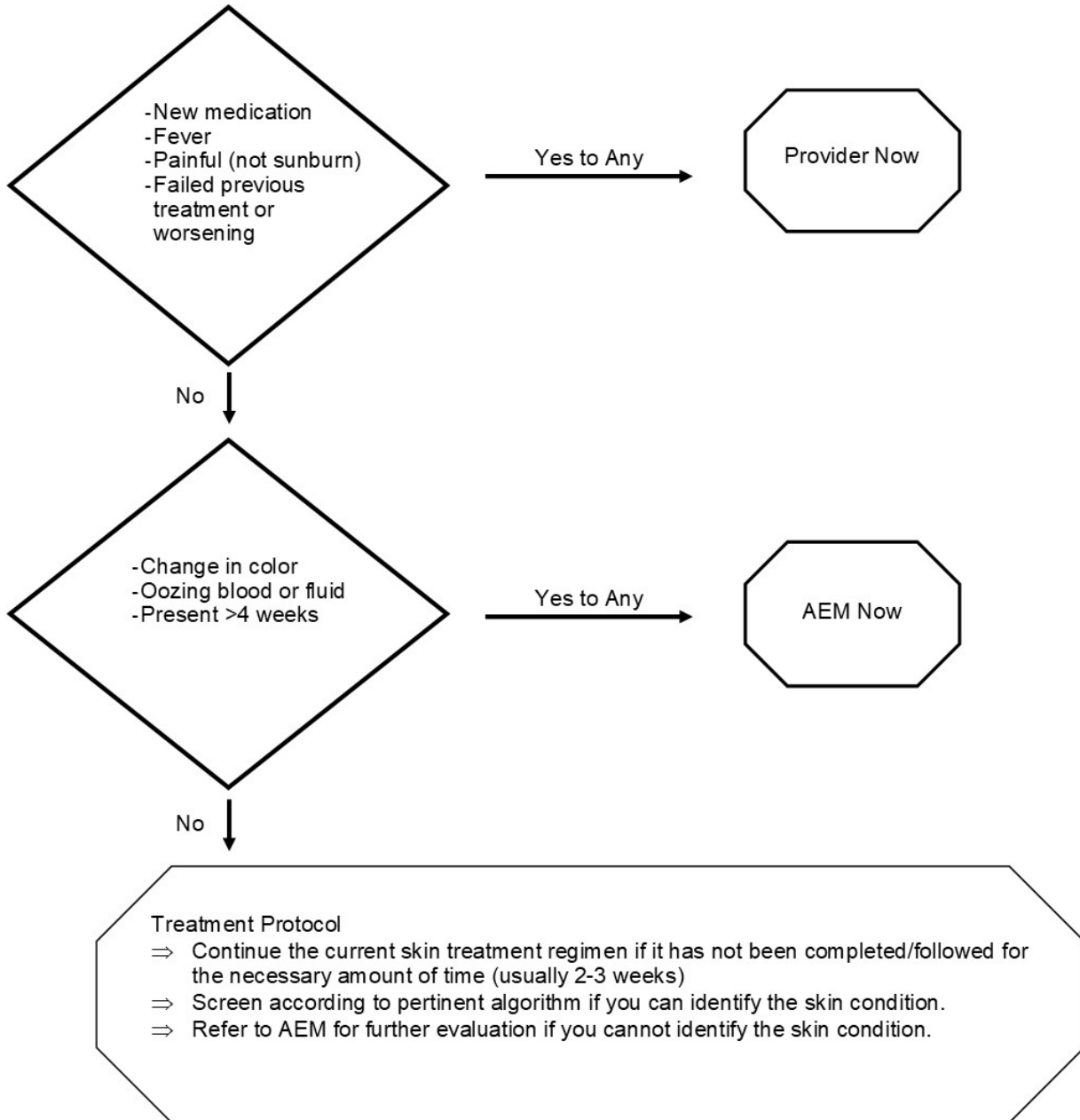
TREATMENT PROTOCOL, J-1

MCP for unidentified skin disorder. If the Soldier is already on a treatment for this issue, has not finished the current treatment, and the issue is not getting worse, then instruct the Soldier to continue with the current treatment for the full course. Some skin issues can take two to three weeks or potentially longer for them to work. Confirm with your supervising NCO or supervising privileged provider before returning the Soldier to work. If you recognize the skin lesion, then screen according to the identified skin condition. If you do not recognize the skin lesion, refer the Soldier to the AEM for further evaluation.

J-1: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
J-1: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

UNKNOWN CAUSE OF SKIN DISORDER/COMPLAINT, J-1

Partial Differential Diagnosis Eczema Hives Contact Dermatitis Athlete's Foot Heat Rash Drug Reaction	RED FLAGS - Airway Compromise/ Swelling	Activity Modification: Keep area clean and dry
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ACNE, J-2

Acne is caused by plugged oil glands. The oily material may form a ‘whitehead’ or develop a dark colored ‘blackhead’ when exposed to the air. Pimples develop when these plugged glands become inflamed and bacteria begin breaking down the oil-producing irritating substances as by-products. Acne is a common condition occurring primarily in the late teens and early twenties. Acne may be extremely upsetting to the young Soldier. The seriousness of this condition or its importance to the Soldier must not be underestimated. With proper treatment, acne can be improved thus avoiding scarring.

Red Flags. None.

DP 1: Birth control and a positive hCG requires additional counseling that should be provided by the supervising privileged provider. Hyperandrogenism requires additional evaluation. Draining lesions requires more aggressive therapy. Acute onset of acne symptoms for the first time after age 18 requires further evaluation.

DP 2: Moderate to severe acne or acne on the back or interferes with wearing equipment requires evaluation for oral medications and temporary profile. Scarring and hyperpigmentation requires more aggressive therapy to avoid further permanent scarring. There can be psychological effects from acne. It is important to identify Soldiers that are very self-conscious and escalating the treatment regimen to quickly control the acne.

TREATMENT PROTOCOL, J-2

MCP for acne. All Soldiers with acne should be instructed to wash the affected area with mild soap and water without scrubbing twice a day and pat dry. Avoid creams and lotions to the area.

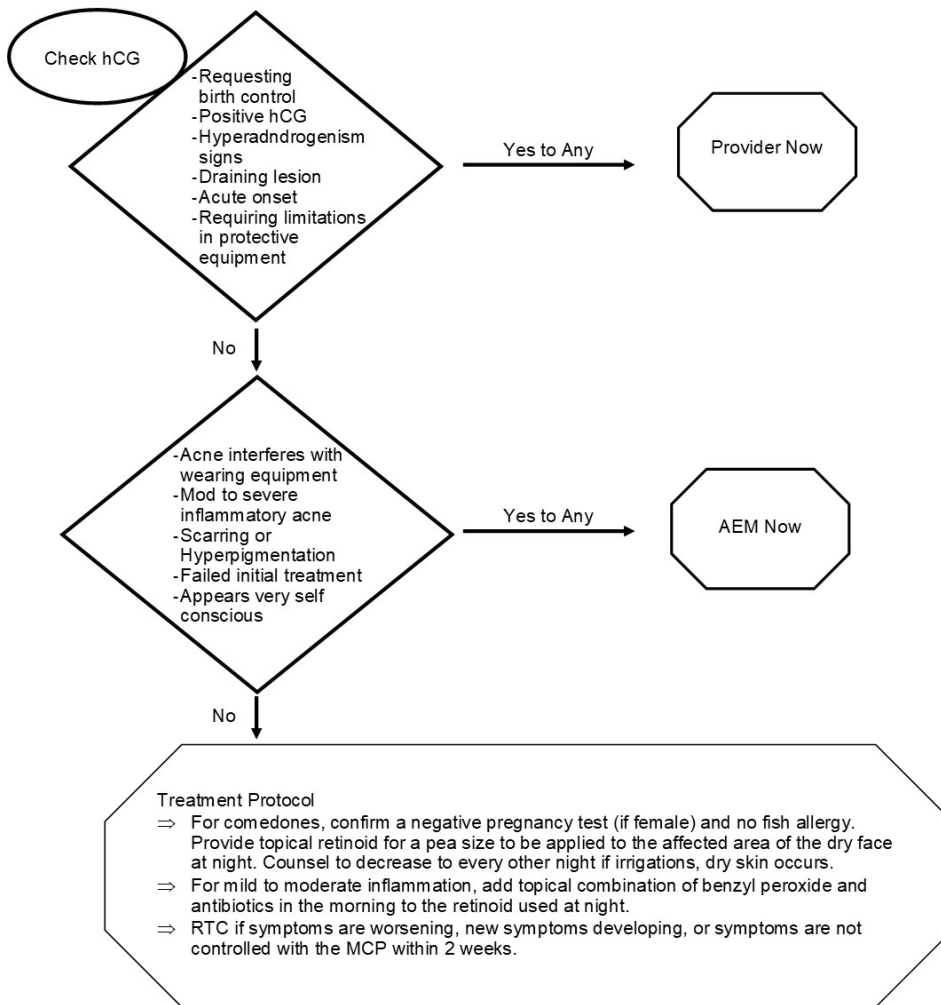
Non-inflammatory acne with closed comedones (white heads) or open comedones (black heads) can be treated with a topical retinoid. **Retinoids should not be prescribed during pregnancy or if have fish allergy.** Instruct Soldier to apply a pea sized amount of medication to a dry face at night. Treat the whole area (don’t spot treat) due to its preventative effect on acne. Don’t combine use with harsh soaps or other acne treatments. If skin irritation occurs, decrease use to every other night.

Mild to moderate inflammatory acne with papules can be treated with the addition of topical benzoyl peroxide with an antibiotic in the morning. Benzoyl peroxide should not be applied at the same time as a retinoid due to decreasing the retinoid’s effectiveness. Instruct to return to clinic if not improving within two weeks, getting worse, or side-effects from the medications are occurring.

J-2: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
Obtain Laboratory Specimens(urine for HcG)	pg.69-70	(2)(k)
J-2: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

ACNE, J-2

Partial Differential Diagnosis Acne Vulgaris Pseudofolliculitis Barbae Folliculitis Acne Rosacea Hyperandrogenism	RED FLAGS - None	Activity Modification: None
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SHAVING PROBLEM-PSEUDOFOLLICULITIS BARBAE (INGROWN HAIRS), J-3

Pseudofolliculitis barbae is a chronic condition of the beard area resulting from the reentry of the growing hair into the upper layer of the skin or facial hairs becoming trapped in the upper layer of the skin. The genetic predisposition of the African-American male to tight coiling hair makes him highly susceptible to this condition. The most common locations for lesions are the face and neck. The lesions can be painful and interfere with shaving although they rarely become secondarily infected. Permanent scarring is possible.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Facial cellulitis or a draining abscess are signs of a skin infection and not pseudofolliculitis barbae. These conditions require further evaluation and treatment. Cellulitis of the face can have life threatening complications.

DP 2: After failure of conservative therapy and lifestyle modifications, a permanent profile may need to be considered. Refer to the AEM for counseling prior to initiating the next step in therapy.

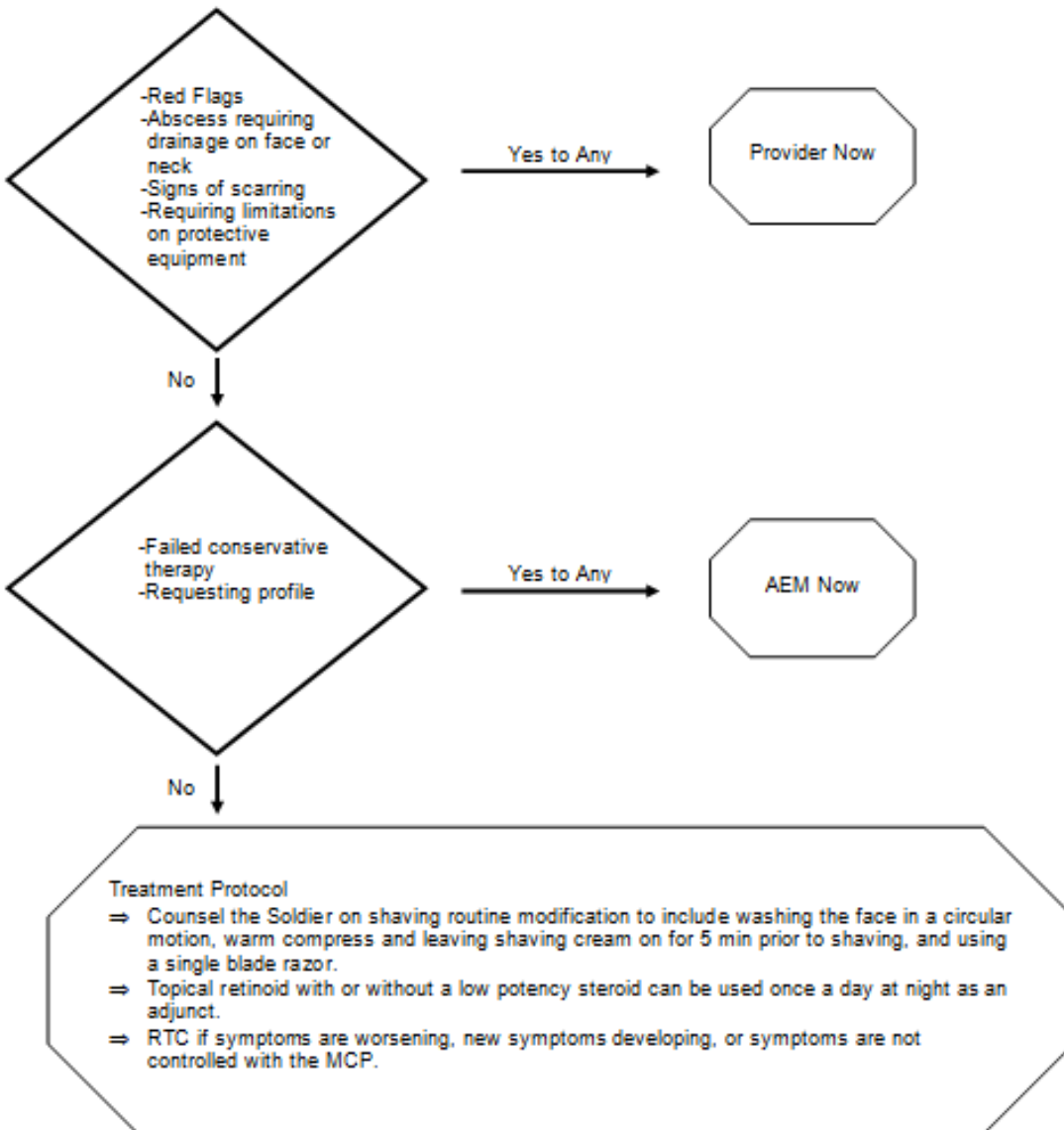
TREATMENT PROTOCOL, J-3

Shaving routine modifications are the first line in treatment. The following adjustments can help reduce the penetration of the inter-follicular skin by the hair shaft. Instruct the Soldier to wash the face in a circular motion with soap and warm water once a day to free any embedded hairs. Use a warm compress or warm water on the face before shaving and apply generous amounts of shaving cream for 5 minutes before shaving to soften the hair. Use a single blade razor, shave in the direction of hair growth, and avoid stretching the skin during shaving to reduce the production of very short hairs. Medication can be used in conjunction with the shaving routine modifications. A topical retinoid at night with or without the combination of a low potency topical steroid. Bumps associated with pseudofolliculitis barbae can remain for a few months after treatment has been started. Instruct the Soldier to return if the symptoms are worsening, new symptoms develop, or the minor-care protocol does not appear to be helping after a few weeks.

J-3: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
J-3: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

SHAVING PROBLEM-PSEUDOFOLLICULITIS BARBAE (INGROWN HAIRS), J-3

Partial Differential Diagnosis Acne Pseudofolliculitis Barbae Folliculitis Tinea Barbae Acne Keloidalis Nuchae	RED FLAGS - Facial Cellulitis	Activity Modification: Shaving profile in eProfile
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DANDRUFF (SCALING OF THE SCALP), J-4

Dandruff which is also known as pityriasis sicca, is the mildest and most common form of scalp seborrheic dermatitis. White scales or flakes on the head or hair with mild itching are the most common symptoms.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.”

DP 1. Visible inflammation with patchy, orange to salmon-colored or grayish plaques covered with yellowish, greasy scales, concretions of scale around hair shafts, lesions consisting of fissures, oozing, and crusting, are all signs of a more severe form of scalp seborrheic dermatitis.

DP 2. Dandruff, can be a chronic relapsing condition even in its mild form. All antifungal shampoos are not the same and Soldiers may have different responses to them. OTC treatment may take some trial and error to find the shampoo that is right for the Soldier. Inflammation, lesions with oozing and crusting are signs that the symptoms are getting worse and the Soldier needs to be evaluated inside of a clinic setting.

TREATMENT PROTOCOL, J-4

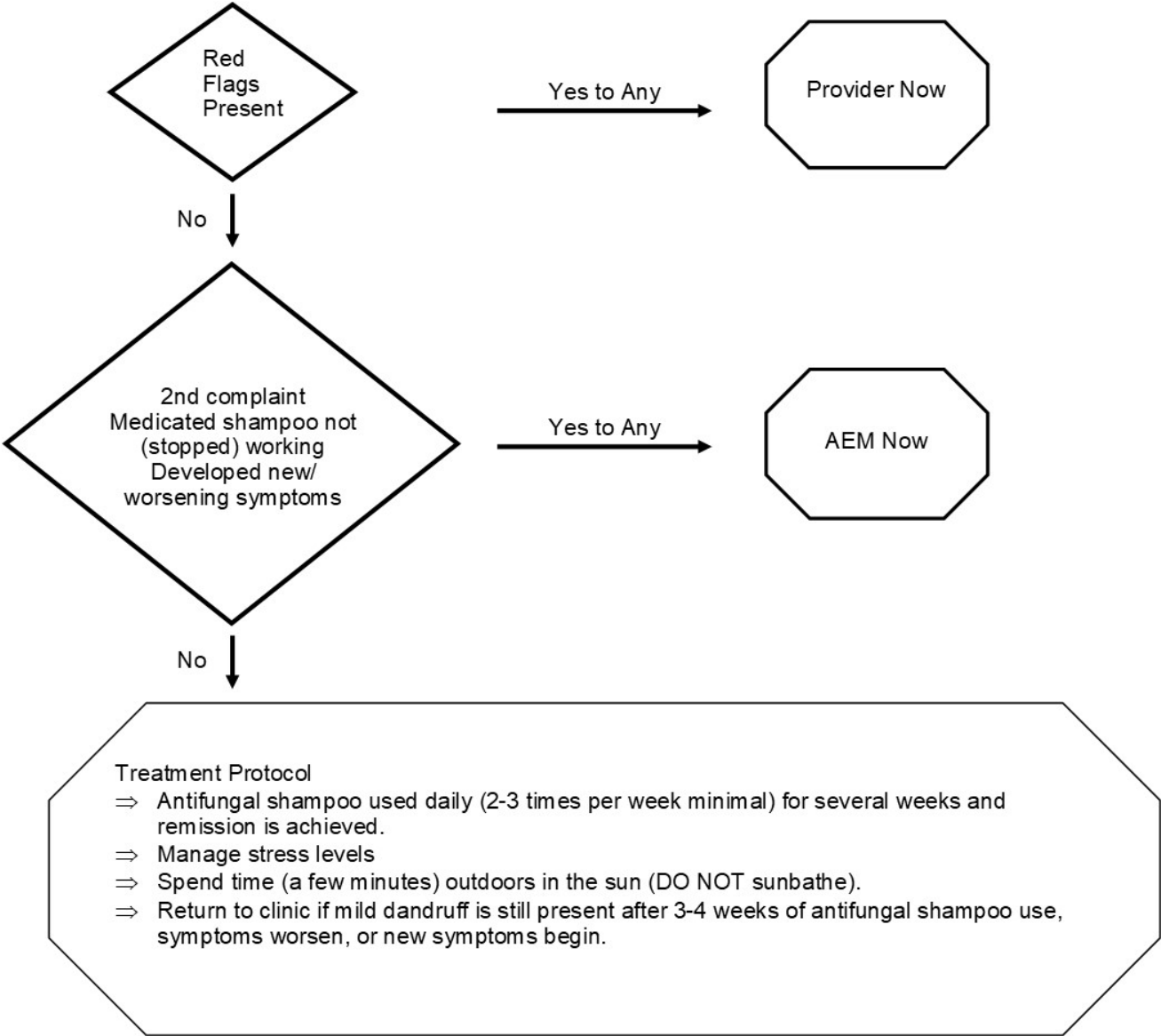
MCP for dandruff. There are some risk factors that make a Soldier more susceptible. Some risk factors include if the Soldier is male, Soldier has excessively oily skin and hair and/or if the Soldier suffers from certain diseases (for example, Parkinson’s disease, HIV).

OTC medication: Antifungal shampoo used daily (2-3 times per week minimal) for several weeks and remission is achieved. Manage stress levels, spend time (a few minutes) outdoors in the sun (DO NOT sunbathe). OTC medication: Antifungal shampoo used daily (2-3 times per week minimal) for several weeks and remission is achieved. Instruct the Soldier to seek medical assistance if mild dandruff is still present and not improving after three to four weeks of antifungal shampoo use, symptoms worsen, or new symptoms begin.

J-4: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

DANDRUFF (SCALING OF THE SCALP), J-4

Partial Differential Diagnosis Pemphigus Foliaceus Tinea Capitis Psoriasis Allergic Contact Dermatitis Seborrheic Dermatitis	RED FLAGS - Scaling with Visible Inflammation - Abnormal Sensation - Painful Erosions	Activity Modification: None
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HAIR LOSS, J-5

While most hair loss is natural and hereditary, any hair loss that is sudden or extreme in nature may have resulted from a fungal infection or other forms of illness or as a result of using certain medications. When treated promptly and properly, hair growth typically resumes.

Red Flags. None.

DP 1: Examples of medications that can result in hair loss are propranolol, ketoconazole, isotretinoin, colchicine, and cholesterol medications. If hair follicles are not present on exam, then scarring hair loss is more likely requiring a referral to dermatology. Alopecia areata is described as smooth, circular discrete hair loss that occurs over a couple of weeks. Refer to a privileged provider for consideration of intra-lesion steroid injections.

DP 2: Tinea capitis is a fungal infection of the scalp that presents with itching, scaling, and hair loss. It is common in kids but can occur in adults. Treatment is with an oral antifungal. Papules, pustules, and erythema are signs of inflammation which require further evaluation.

TREATMENT PROTOCOL, J-5

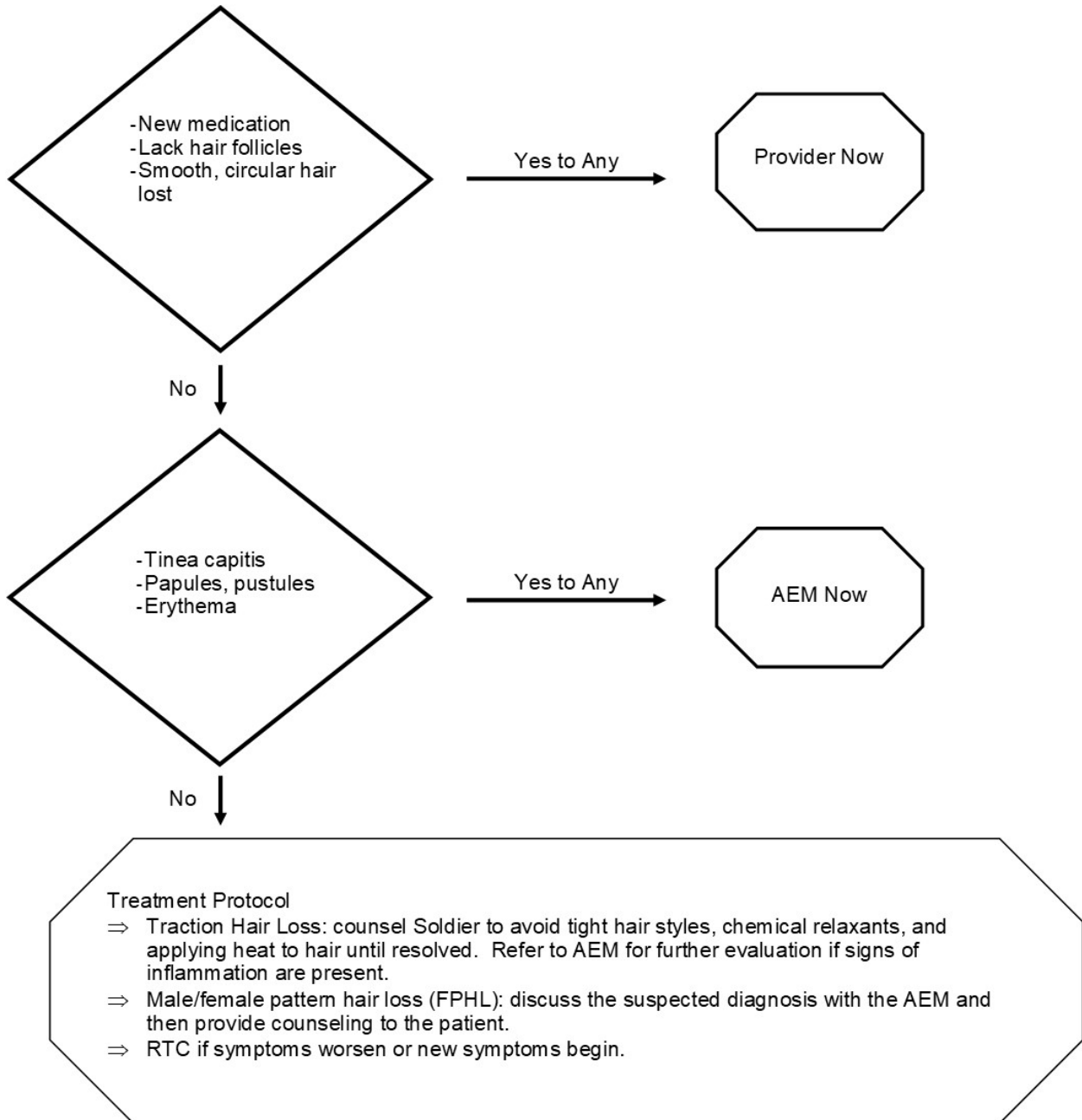
MCP for traction hair loss: Hair loss associated with traction being applied to hair for an extended period of time from tight hair styles often over the frontal and temporal areas. It is associated with traction folliculitis which includes erythema, papules, and sterile pustules. Instruct Soldier to avoid tight hair styles, chemical straighteners, and heating the hair follicle (for example, curling iron, straight iron) until it has resolved. Refer to AEM if signs of inflammation are present to evaluate for treatment with a high potency topical steroid or intra-lesion steroid inject.

MCP for male/female pattern hair loss: Male pattern hair loss often occurs after age 30 with hair loss over the frontal, temporal, and top of the head. On examination, hair follicles with a decreased caliber will be seen. Female pattern hair loss occurs over the front and top of the head. It most often occurs after menopause. Instruct the Soldier on the diagnosis.

Refer to AEM if does not meet either of the above patterns. Return to clinic if symptoms worsen or new symptoms develop.

HAIR LOSS, J-5

Partial Differential Diagnosis	RED FLAGS - None	Activity Modification: None
Alopecia Traction Hair Loss Alopecia Areata Tinea Capitis Acne Keloidalis Nuchae		



ATHLETE’S FOOT (TINEA PEDIS), J-6

Tinea pedis (athlete's foot) most commonly occurs with frequently wearing damp socks and/or tight fitting shoes. It is contagious and can be spread by contact with an infected person or contaminated surface.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.”

DP 1. Peeling, cracking, redness, blisters, and breakdown of the skin with itching and burning are characteristics of both dry skin and athlete’s foot. If untreated, the fungal infection can lead to a severe secondary bacterial infection.

DP 2. Some fungal infections are unresponsive to topical medications and a systemic antifungal treatment is required. Ulcers increase the risk of a secondary bacterial infection.

TREATMENT PROTOCOL, J-6

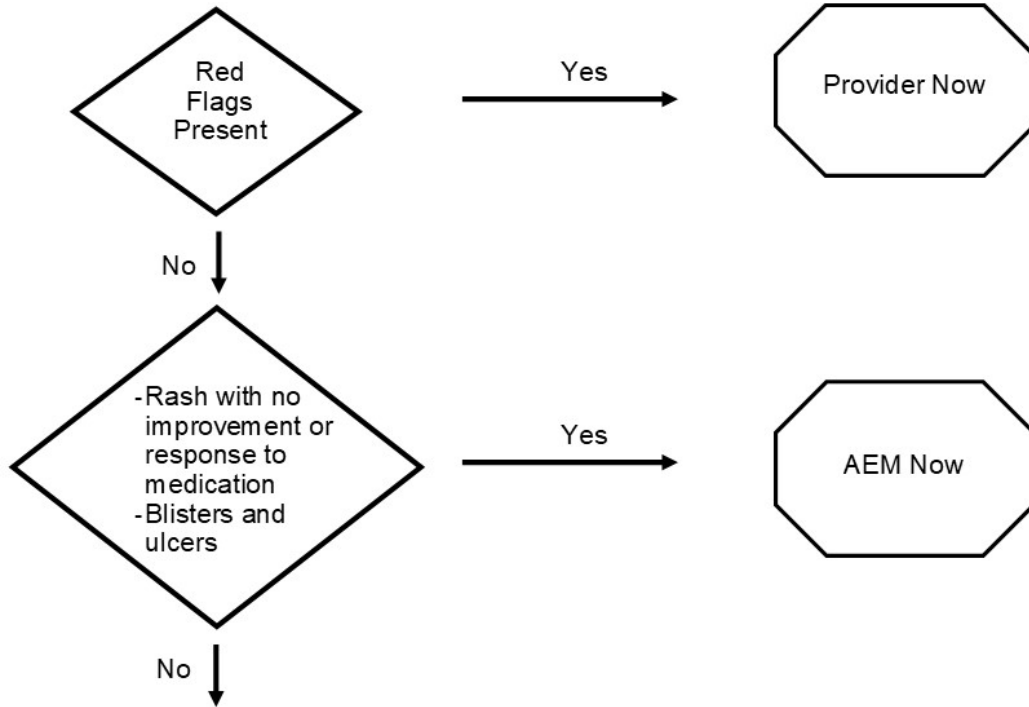
MCP for athlete’s foot. This type of fungal infection requires keratin for growth, which restricts the infection to the superficial skin, hair, and nails. Interdigital tinea pedis, hyperkeratotic (moccasin-type) tinea pedis and vesiculobullous (inflammatory) tinea pedis are the 3 major categories of tinea pedis infections.

OTC medication: topical antifungal therapy can used to cure a fungal infection which has no secondary infection. Antifungal cream is applied twice a day for one week. Instruct the Soldier to return to the clinic if the fungal infection does not respond to OTC medications, symptoms worsens, new symptoms develop. Prevention measures: Athlete's foot can be spread through direct and indirect contact. Direct, skin-to-skin contact, occurs when an uninfected person touches the infected area of somebody with athlete's foot while indirect contact, is when the fungi can infect people via contaminated surfaces, clothing, socks, shoes, bed sheets, and towels. Instruct Soldier to keep his or her feet clean and dry, change socks regularly, wear well ventilated shoes and provide feet protection in public places. Use antifungal powder daily, alternate shoes and do not share shoes.

J-6: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
J-6: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

ATHLETE'S FOOT (TINEA PEDIS), J-6

Partial Differential Diagnosis Interdigital tinea pedis Hyperkeratotic (moccasin-type) tinea pedis Vesiculobullous (Inflammatory) tinea pedis	RED FLAGS - Diabetic Soldiers - Significant erosions/ ulcerations or malodor in affected area - Soldiers w/weakened immune systems	Activity Modification: None
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Treatment Protocol

- ⇒ Antifungal lotion, ointment, powder or spray-applied twice a day for 4-8 weeks.
- ⇒ RTC if the fungal infection does not respond to medications, symptoms worsens, new symptoms develop.

Prevention

- ⇒ Instruct patient to keep their feet dry, change socks regularly, wear well ventilated shoes and provide feet protection in public places. Use antifungal powder daily, alternate shoes and do not share shoes.

JOCK ITCH (TINEA CRURIS), J-7

Tinea cruris (also known as jock itch) is a dermatophyte infection involving the crural (superior medial portion of the thigh) fold. The spreading of tinea pedis is often the cause for these infections. Infection may spread to the perineum and perianal areas, into the gluteal cleft, or onto the buttocks.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.”

DP 1. Diabetes can affect every part of the body, including the skin. Soldiers with diabetes are more susceptible to skin conditions such as bacterial infections and fungal infections. Although common infections can be self-treated, the Soldier should see a privileged provider to rule out other more serious diabetic related skin conditions.

DP 2. Some infections and rashes do not respond well to OTC medications and infections may not get better or may reoccur within a few weeks. These Soldiers need to be evaluated to rule out more serious skin conditions. A normal infection may respond better to a prescription strength antifungal.

Note: In the absence of any of the preceding conditions, minor-care is appropriate.

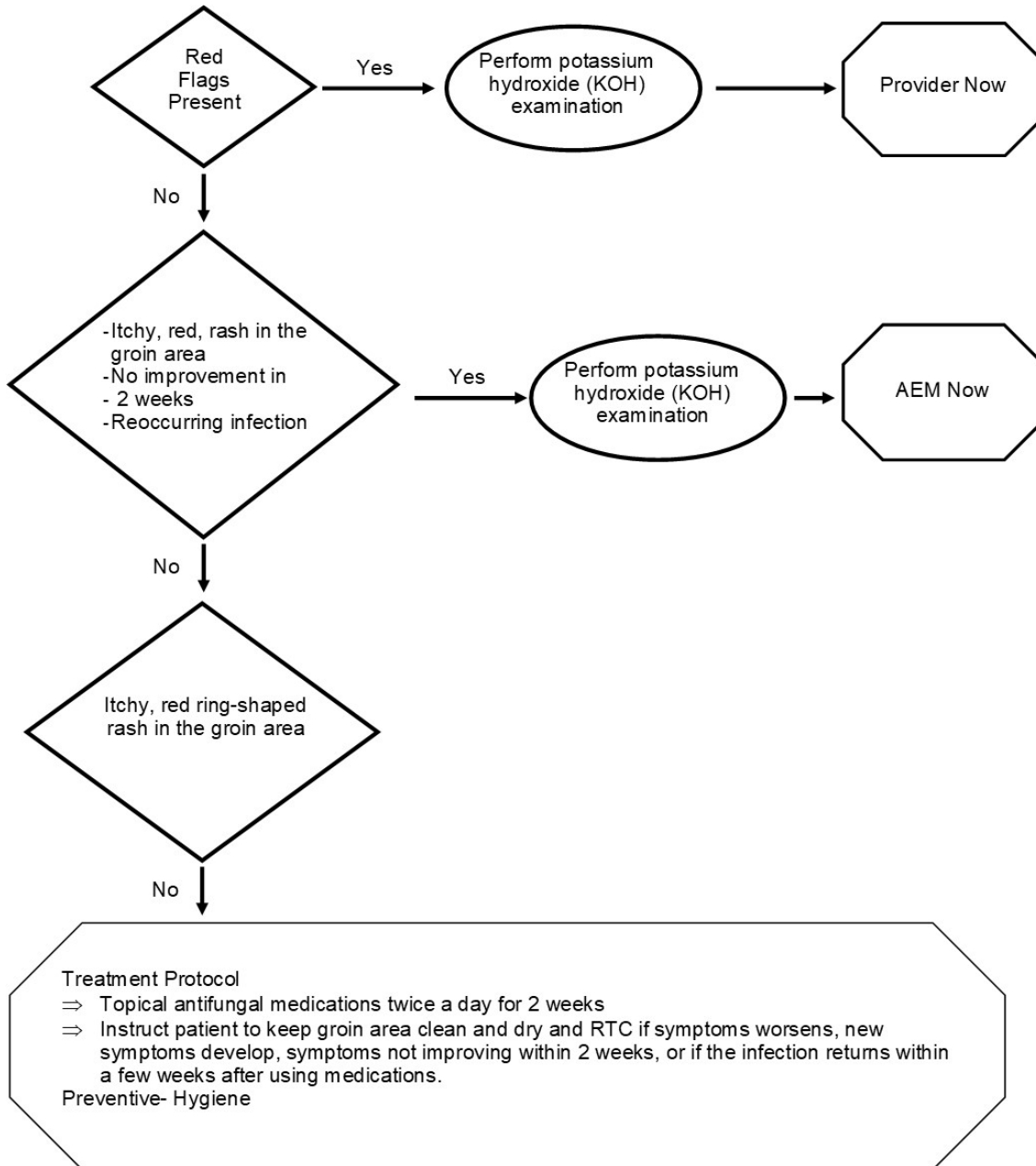
MCP for jock itch. Tinea cruris is far more common in men than women. Predisposing factors include copious sweating, obesity, diabetes, and immunodeficiency.

OTC medication. Topical antifungal medication twice a day for two weeks. Instruct Soldier to keep groin area clean and dry and return to clinic if symptoms worsens, new symptoms develop, symptoms not improving within two weeks, or if the infection returns within a few weeks after using OTC Medications.

J-7: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
J-7: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

JOCK ITCH (TINEA CRURIS), J-7

Partial Differential Diagnosis Inverse psoriasis Erythrasma Seborrheic dermatitis Candidal intertrigo	RED FLAGS - Diabetes - Immunodeficiency	Activity Modification: None
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SCALING, DEPIGMENTED SPOTS ON THE CHEST, BACK, AND UPPER ARMS (TINEA VERSICOLOR), J-8

Tinea versicolor is a common superficial fungal infection that appears as “spots” (lighter, darker, or redder than surrounding skin) on the neck, chest, back, and arms usually with no other symptoms. The rash is typically scaly and painless. It may be noticed in the summer when affected areas fail to tan after sun exposure.

Red Flags. None.

DP 1: Tinea versicolor that has failed initial therapy or is widespread may require systemic treatment. Presence of scale in the area and a positive potassium hydroxide (KOH) test confirms treatment failure requiring systemic treatment. Refer to the supervising privileged provider for counseling and evaluation for treatment.

DP 2: Tinea versicolor often reoccurs. When this occurs, additional counseling to the Soldier is required to help prevent further occurrences. Refer to the AEM for additional counseling and preventative measures. If it is an atypical presentation that you do not recognize, refer to the AEM for further evaluation and treatment.

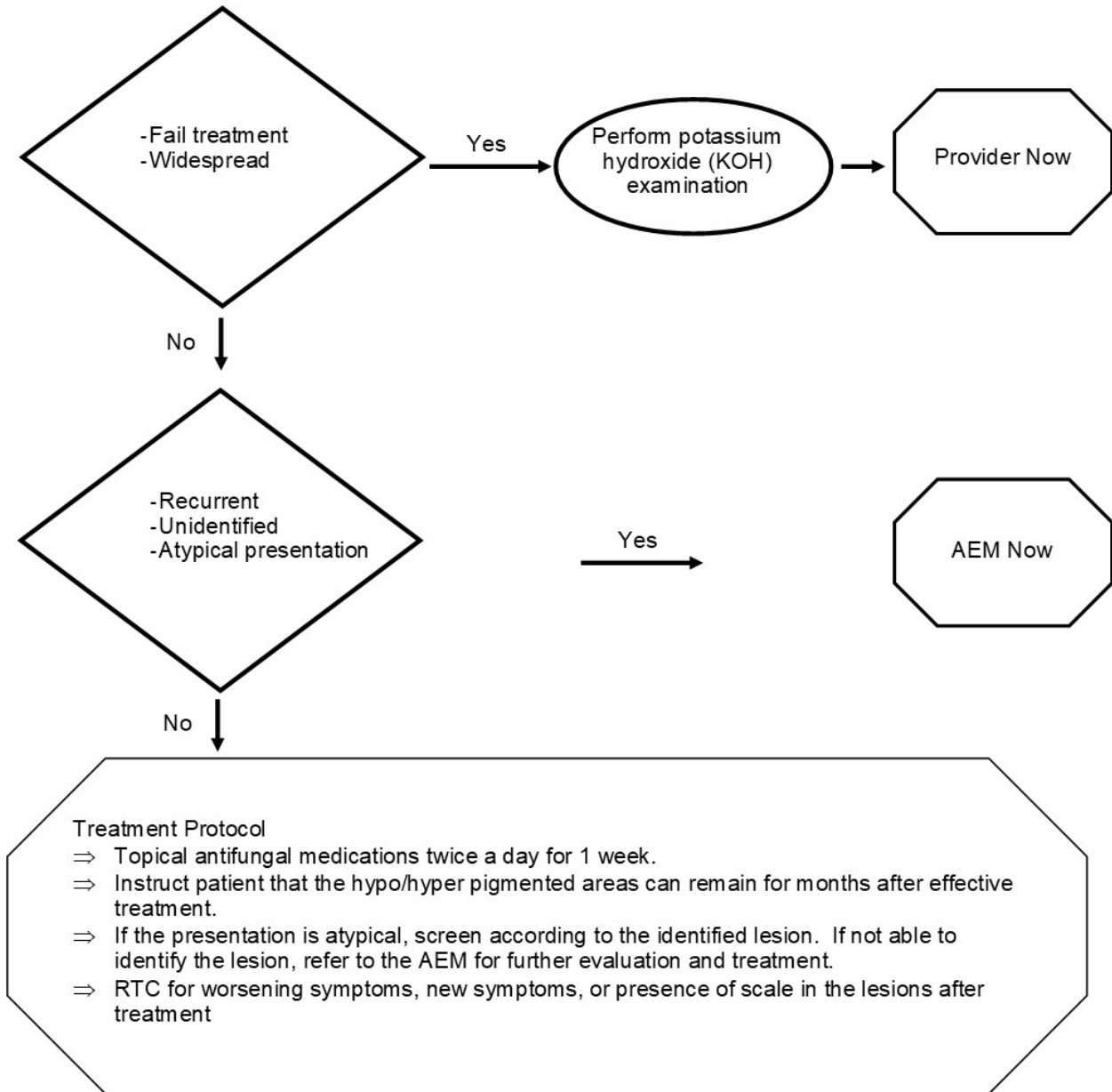
TREATMENT PROTOCOL, J-8

MCP for tinea versicolor. Treat with topical terbinafine twice a day for one week. Selenium sulfide 2.5% shampoo lathered over the affected area and left for 10 minutes once a week is also effective. Instruct the Soldier that hypo/hyperpigmentation of the area may remain for months after effective treatment. If the presentation is not classic for tinea versicolor, screen according to the appropriate protocol and discuss with the AEM. Return to the clinic for worsening symptoms, new symptoms, or presence of scale in the lesions after treatment.

J-8: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
J-8: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

SCALING, DEPIGMENTED SPOTS ON THE CHEST, BACK, AND UPPER ARMS (TINEA VERSICOLOR), J-8

Partial Differential Diagnosis	RED FLAGS	Activity Modification:
Seborrheic dermatitis Tinea corporis Vitiligo Secondary syphilis	- None	None



BOILS, J-9

A boil is usually caused by bacteria that enters through a hair follicle. A painful nodule enclosing a core of pus forms in the skin. Tenderness, warmth, swelling, and firm area, and pain may be present around the area of inflammation. An extremely large boil or numerous boils can produce fever. Boils are also known as furuncles if they have single cores or carbuncles if they have multiple cores.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Pilonidal abscesses (over the tail bone) can be much larger than they appear and should be referred to a privileged provider for evaluation. Systemic inflammatory response syndrome (SIRS) criteria, fever, black eschar, rapid progression over hours, and worsening on oral antibiotics are signs of a more significant infection that may require hospitalization. Hand infection, infection over a joint, indwelling medical device, and associated cellulitis increases the risks of serious complications.

DP 2: An abscess should be drained to allow it to heal, and an abscess with a diameter of greater than 5 cm will need to be packed. Military population is at risk for community transmission of staphylococcus aureus and should be evaluated for the addition of antibiotic therapy.

TREATMENT PROTOCOL, J-9

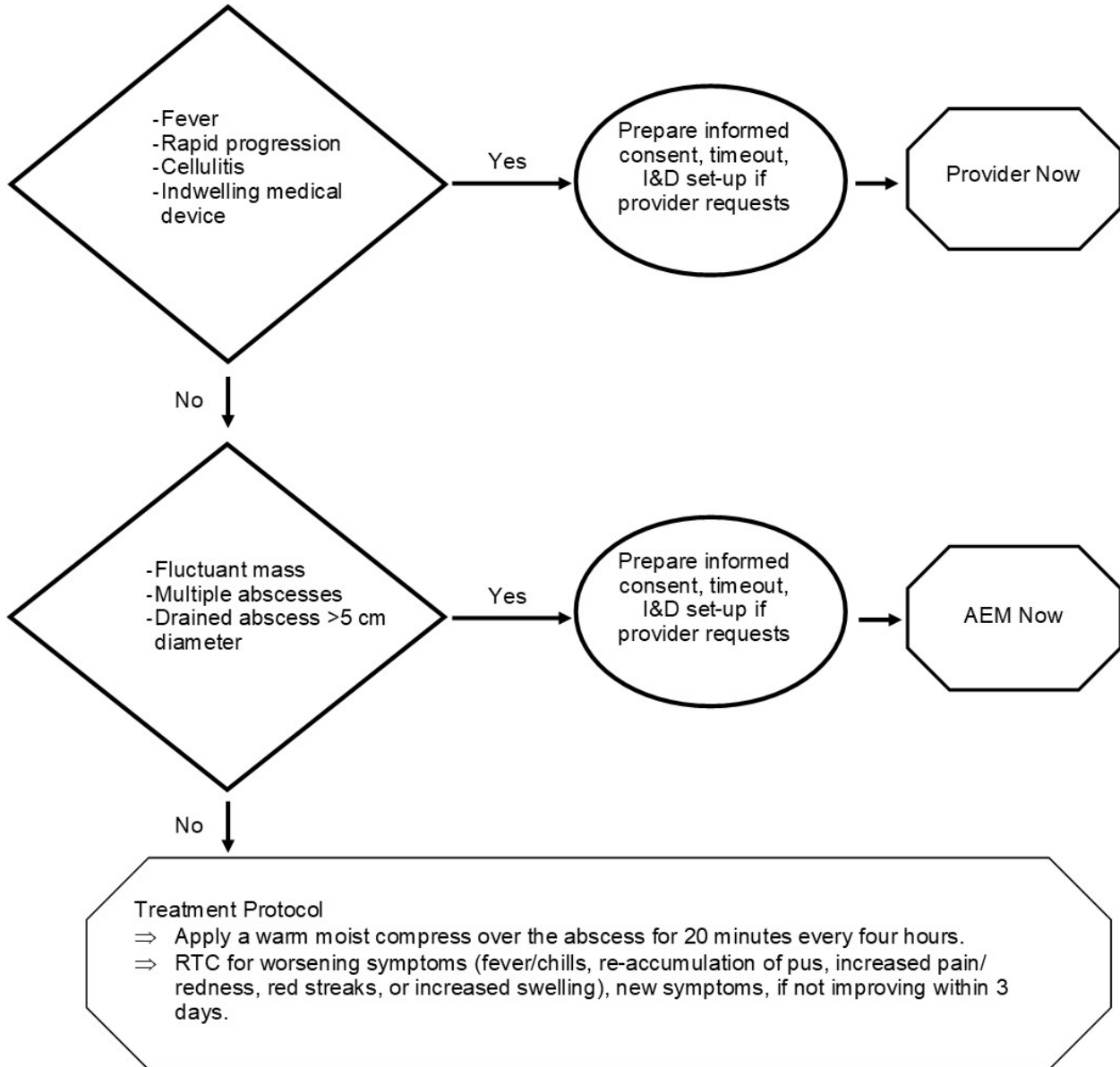
MCP for skin infection. Prior to abscess formation, the skin normally becomes indurated from the inflammation. The skin appears to be warm, red, and tender with a hard area where the inflammation is present. Treatment is minor-care. An abscess may form within a couple of days requiring further treatment.

Apply a moist, warm compress over the area for 20 minutes every four hours. It will increase blood flow to the area, allowing the Soldier’s immune system to fight the infection. Instruct the Soldier to return to the clinic after the abscess forms for drainage. Return sooner, if symptoms worsen (for example, fevers, chills, increased pain or redness, red streaks, increased swelling, or re-accumulation of pus, if it has already drained).

J-9: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

BOILS, J-9

Partial Differential Diagnosis Folliculitis Abscess Epidermal Cyst Hidradenitis Suppurativa Septic Joint	RED FLAGS - Location over Tailbone - SIRS Criteria - Worsening on Antibiotics - Palm of Hand - Over Joint - Black Eschar	Activity Modification: -None
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FEVER BLISTER (COLD SORES), J-10

Fever blisters result from an acute viral infection that frequently occurs around the mouth or on the lips. Fever blisters usually occur with multiple vesicular lesions on an erythematous base. Lesions can be painful and last for 10-14 days. Initial infection can be associated with systemic symptoms, like fever and malaise. Viral infection resides in the nerve cells after the initial infection and can reoccur when the body is under stress. Re-emergence of the cold sores is often preceded by prodromal symptoms of pain, burning, tingling, or itching for 6 hours to 2.5 days. Cold sores are contagious and spread through contact.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: HSV-1 infection can occur at any mucosal or skin site. Although rare, eye infection with HSV causes keratitis. Eczema and burns result in breaks in the skin’s natural protective barrier increasing the risk of spreading the HSV infection to these areas.

DP 2: Elevated temperature, sore throat, sores on the hand, and moderate to severe pain increase the chance of an alternative viral infection or initial infection requiring further evaluation and possible systemic antiviral therapy. Pustules and yellow, honeycomb crusting suggest a bacterial infection requiring further evaluation.

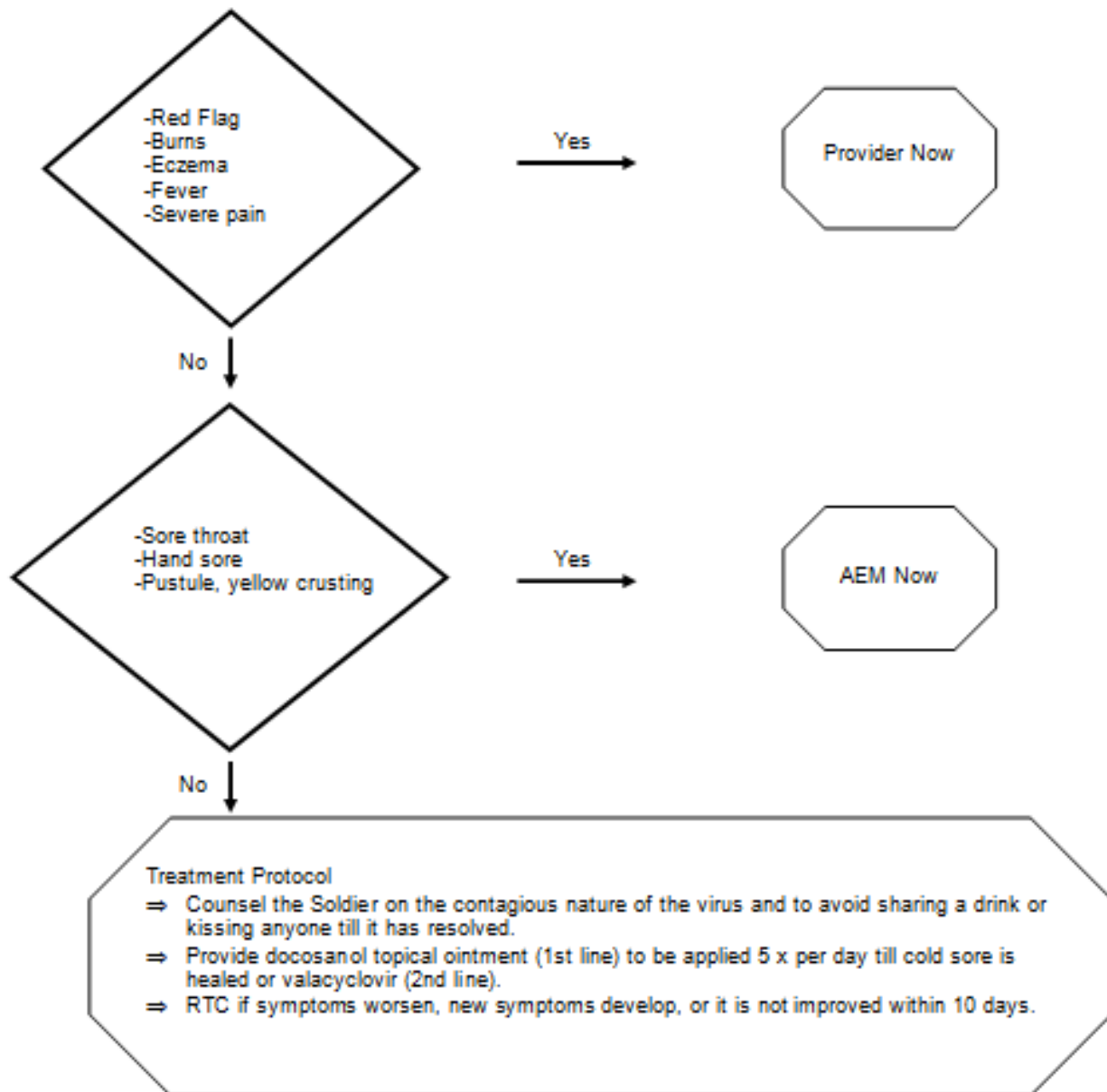
TREATMENT PROTOCOL, J-10

MCP for fever blister. Instruct Soldier on contagious nature of HSV-1, cold sores. Soldier is contagious a little all of the time. When symptomatic or cold sores are present, the Soldier is very contagious, and the virus is spread through direct contact. Instruct the Soldier to avoid sharing drinks or kissing anyone till after it has resolved. Provide docosanol (Abreva) topical ointment to be applied to the cold sore five times a day or two doses of valacyclovir (2g), 12 hours apart. Return to clinic if symptoms are worsening, new symptoms develop, or it is not improved within 10 days.

J-10: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
J-10: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

FEVER BLISTER (COLD SORES), J-10

Partial Differential Diagnosis Cold Sore Aphthous Ulcer Epstein-Barr Virus Syphilis	RED FLAGS - Eye Pain	Activity Modification: -None
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SKIN ABRASION/LACERATION, J-11

Skin abrasions are caused when the skin is rubbed raw such as when a knee or elbow is scraped. While this type of injury is painful, it normally requires only minor treatment.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: SIRS criteria includes two of the following: heart rate over 90 bpm, respiratory rate over 20, Temp >100.4° F or <96.8° F, or WBC >12,000 cells. SIRS criteria with a source of infection is sepsis and requires prompt treatment. Fever, red streaks, and oozing wounds indicate an infection that requires further evaluation and treatment. Puncture wounds, avulsions, from crushing or burns, and wounds contaminated with dirt, saliva, or feces require tetanus if not given within last 5 years. Clean wounds require tetanus if not given within last 10 years. High risk wounds increase the risk of complications. Bite wounds have a risk of infection. Lacerations over a joint, on the face, or on the hand or foot have a higher risk of complication from the laceration.

DP 2: Erythema, warmth, and increased tenderness are signs of inflammation or an early infection that requires further evaluation. A laceration needs to be evaluated to determine if it needs to be closed.

TREATMENT PROTOCOL, J-11

Gently wash the affected area with soap and water. If there is a laceration, irrigate inside the laceration using a syringe with jets of sterile saline. While washing and irrigating the wound, ensure that all foreign material has been removed from the wound.

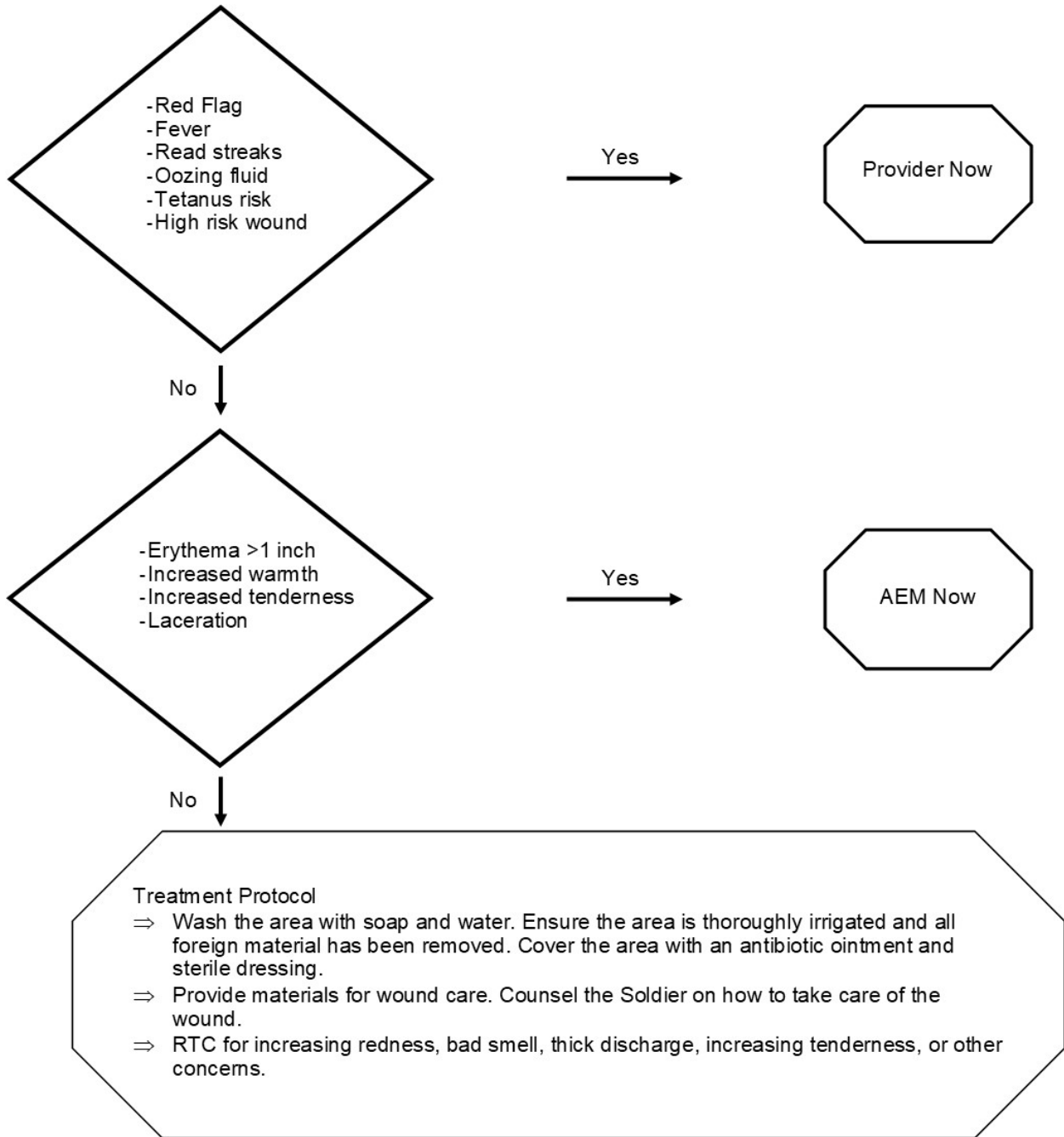
MCP for abrasion: Cover the abrasion with an antibacterial ointment (Bacitracin). Provide the ointment for the Soldier to apply to the abrasion twice a day. Cover the abrasion with a protective, non-stick sterile dressing and have the Soldier change the dressing daily or when saturated with fluid. Keep the area clean and dry.

MCP for laceration: If the edges of the wound can be brought together easily, bleeding is controlled, and there are no signs of infection, minor-care is appropriate. Steri-strips may be applied to keep the skin edges together. If it is a laceration, return to clinic in 24-48 hours for re-evaluation. Otherwise, return to clinic for increasing redness, bad smell, thick discharge, increasing tenderness, or other concerns to include the edges becoming separated.

J-11: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
Perform Wound Care	pg.70	(l)
J-11: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 2: Medical Treatment	Initiate Treatment for a Soft Tissue Injury	081-833-0063

SKIN ABRASION/LACERATION, J-11

Partial Differential Diagnosis Abrasion Laceration	RED FLAGS - SIRS Criteria - Animal Bite, Scratch	Activity Modification: - Keep area clean and dry
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SUTURE REMOVAL, J-12

Sutures should be removed after the skin edges have started to heal together. If sutures are left in too long, it can result in increased scar formation. If sutures are removed too early, the wound can reopen or pull apart at the edges resulting in a larger scar.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Fever, pus, or redness and swelling at the suture location can be a sign of a secondary infection. Refer the patient to the supervising privileged provider for further evaluation and treatment.

DP 2: Incomplete closure should be referred to the AEM to determine the next step in wound care.

TREATMENT PROTOCOL, J-12

Suture should be removed when:

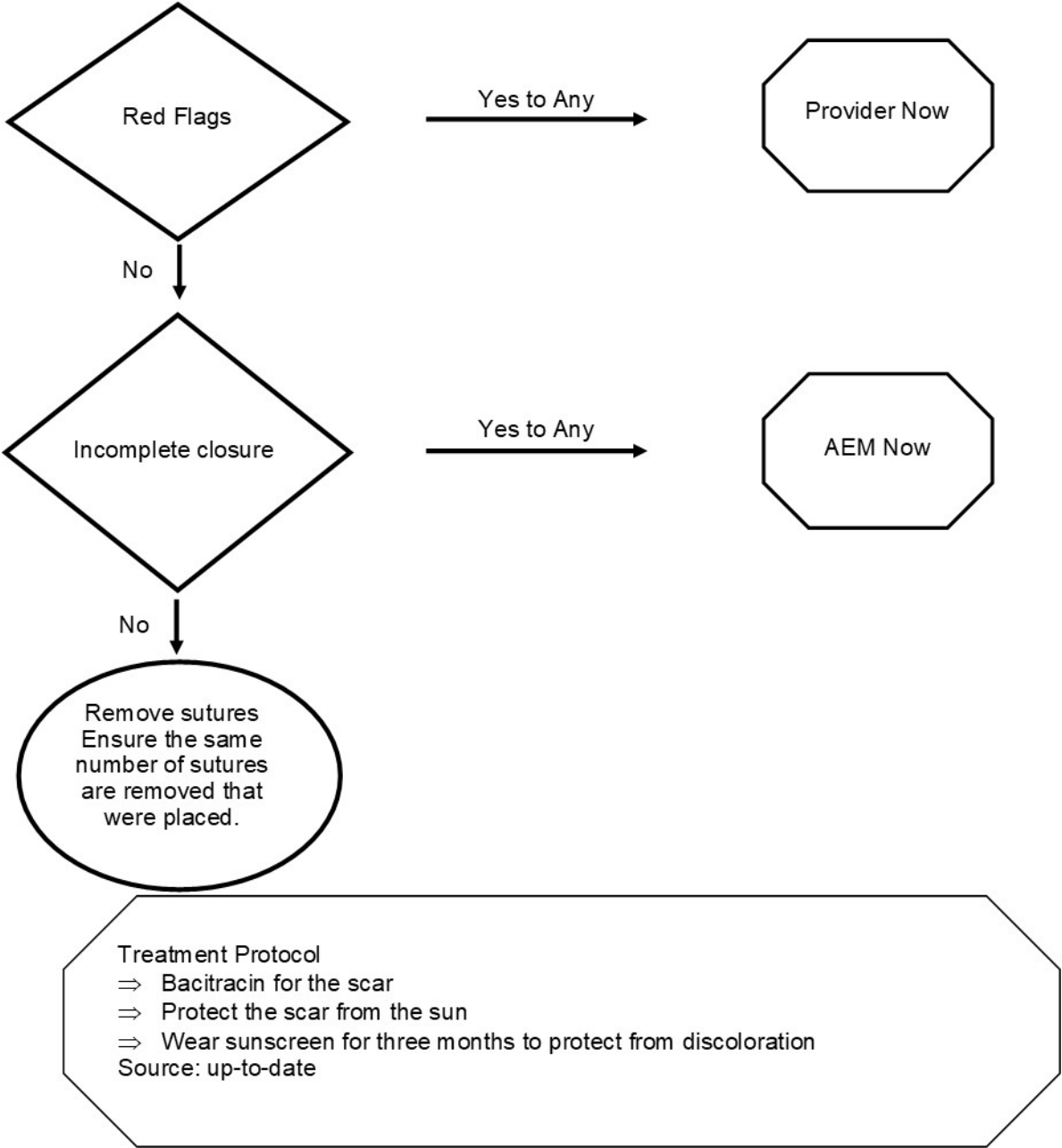
- The wound has healed (within 5 to 10 days).
- The suture line is clean.
- No purulent drainage, redness, or swelling is present.

Document the appearance of the wound (sutured laceration) and number and type of sutures removed. Provide bacitracin if wound edges are still healing. Counsel the patient on wearing sunscreen and sensitivity of the scar to the sun with resulting hyperpigmentation for the first year.

J-12: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
Assists Privileged Provider To Perform Invasive Procedures	pg.68	(5)
Sets Up and Maintains A Sterile Field	pg.68	(7)
Perform Suturing	pg.68	(11)
Perform Wound Care	pg.70	(l)
J-12: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 20: Medical Treatment	Perform Suture Removal	081-833-0026

SUTURE REMOVAL, J-12

Differential Diagnosis None	RED FLAGS - Fever - Pus/redness/swelling	Activity Modification: None
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DRUG RASH/CONTACT DERMATITIS, J-13

Drugs can cause an acute rash of small red spots over the entire body in individuals who are sensitivity to them, like antibiotics or sulfonamides. Contact dermatitis results when the skin comes in contact with anything in the environment that causes an inflammatory reaction, like shoe materials, watchbands, earrings, and poison ivy. Contact area can present with burning, itching, redness, and fissures or vesicles. Poison ivy is the most common example of this group and related to an oil in the plant's leaves. Symptoms usually develop within 24 to 48 hours of contact.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: An allergic reaction can include swelling within the airway, wheezing and breathing problems, to anaphylaxis. Immediate stabilization and treatment is required. Blistering over the body and oral involvement are signs of a more serious drug reaction. Petechial rash and fever are signs of vasculitis (palpable purpura).

DP 2: If the Soldier has not started a medication within the last two weeks, then the rash may not be from a medication. Further evaluation by the AEM is required. Itchy rash (likely hives) with other symptoms needs to be seen by the AEM for evaluation of a more serious reaction.

TREATMENT PROTOCOL, J-13

MCP for hives (urticarial). Caused by the release of histamine from mast cells often related to an allergic reaction and present with circumscribed, raised, red rash with central pallor that moves around. Treatment is avoidance of the irritating substance, if it can be identified. Benadryl at bedtime can help with the symptoms and allow the Soldier to sleep. Provide up to a three day course of the medication.

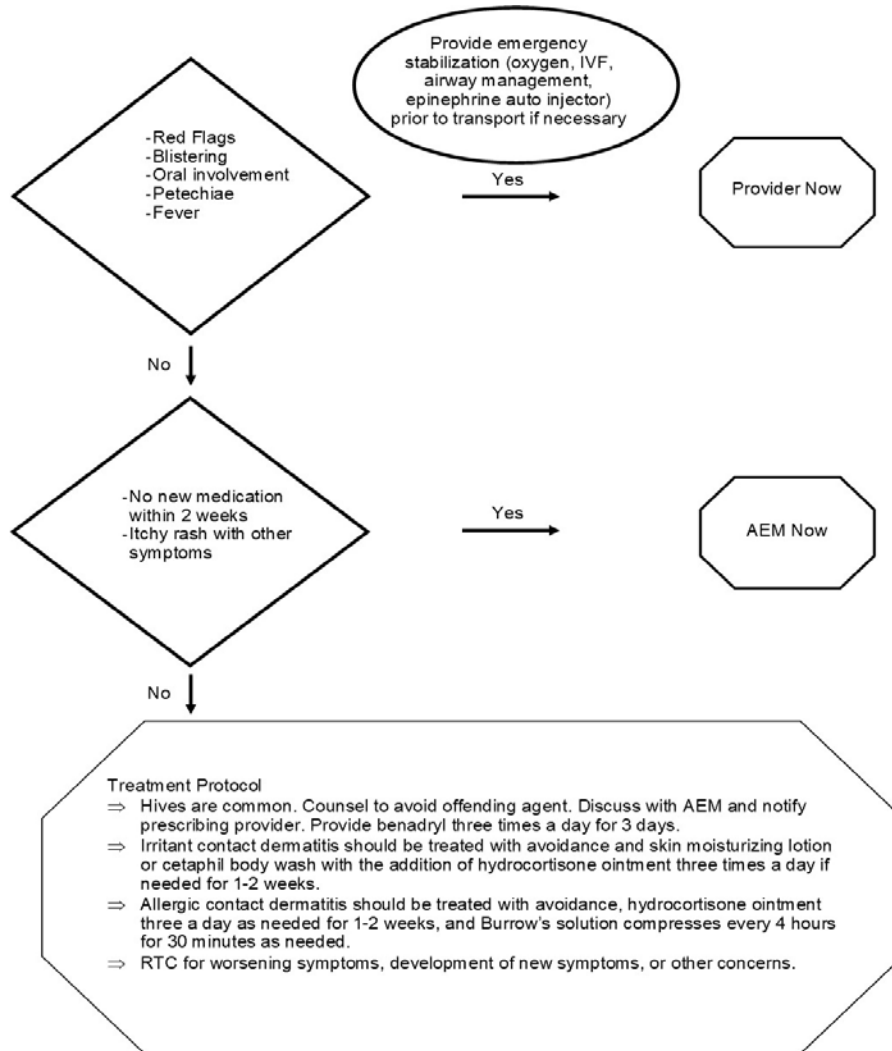
MCP for irritant contact dermatitis. Presents with burning, redness, and may progress to fissures of the skin. Treatment is with avoidance of the irritating substance. Skin lotion to help the skin retain moisture and heal. Hydrocortisone ointment PRN inflammation.

MCP for allergic contact dermatitis. Presents with red, itchy well demarcated area with vesicles, bumps, or scaly skin. Treatment is with avoidance of the irritating substance. Hydrocortisone cream or Burrow's solution compresses can help with the irritation and itching.

J-13: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
J-13: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

DRUG RASH/CONTACT DERMATITIS, J-13

Partial Differential Diagnosis Hives Contact Dermatitis Viral Exanthem Drug Rash	RED FLAGS - Airway Swelling - Wheezing - Anaphylaxis	Activity Limitations: - Avoidance of offending agent - Use latex free gloves or moisturizing soap
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BURNS/SUNBURN, J-14

A burn is defined as any injury to the outer layer of skin or deeper tissue caused by heat, chemicals, or electricity. Minor burns are characterized by redness, pain, and tenderness. More severe burns may not have these symptoms. Sunburn is generalized redness of the skin produced by overexposure to sunlight. Sunburns should be avoided due to repeat occurrences increasing the risk of permanent injury to the skin and increased risk of skin cancer.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: A Soldier with any potential for airway involvement or smoke inhalation causing symptoms should be immediately transported to the nearest qualified or privileged provider. High risk locations for burns include the head, neck, hand, feet, female breast, genitalia, perineum, major joints, and circumferential burns and should be evaluated for referral to a burn center. Partial thickness burns >10% of body surface area, chemical burns, full thickness burns, electrical burns, and burns with associated trauma have a higher risk and should also be evaluated for a burn center. Deep partial thickness (second degree) are painful to pressure only, appear waxy or wet, and do not blanch with pressure. They typically heal within two months.

DP 2: Limited partial thickness (second degree) burns present with red, painful skin that may weep and blisters within 24 hours. These burns typically heal within 3 weeks but require additional management due to risk of secondary infection. Secondary infection (for example, warmth, thick discharge, smell, increasing redness) is a potential complication that should be referred to the AEM. Sunburn of greater than 25% of the Soldier’s body surface area or symptoms of exhaustion should be evaluated for a heat injury.

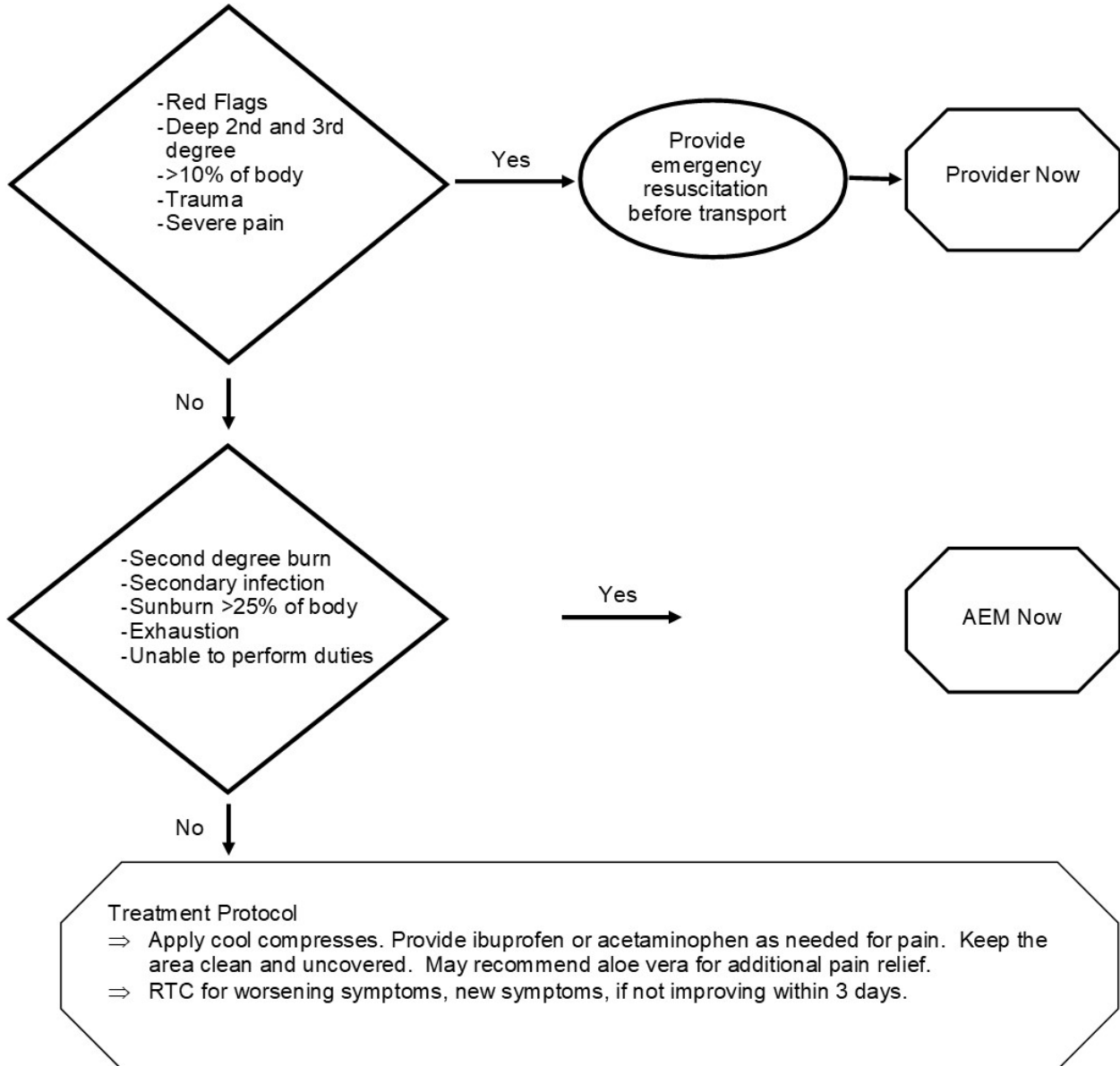
TREATMENT PROTOCOL, J-14

MCP for burns. Superficial burns only include the epidermal layer of skin. They are red and painful but do not blister. The pain and redness typically resolves within three days, and they heal without scarring. Apply cold packs to the affected area as needed for comfort. Leave the area uncovered. Provide acetaminophen or ibuprofen as needed for pain. For sunburn, instruct the Soldier on the importance of using sunscreen, reapplying it every hour, and risks of cancer with repetitive sun damage to the skin. May recommend OTC aloe vera for additional pain relief. Return to clinic for worsening symptoms, new symptoms, or if not improving within three days.

J-14: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
Initial Treatment of Environmental Injuries	pg.69	(2) (e)
J-14: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

BURNS/SUNBURN, J-14

Partial Differential Diagnosis Burn Irritant Contact Dermatitis	RED FLAGS - Trouble Breathing - AMS, Drowsy - High Risk Location - Circumferential Burn	Activity Limitations: Keep area clean -Avoid additional heat exposure to area
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FRICTION BLISTERS ON FEET, J-15

Friction blisters are common and should be treated to prevent complications.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1. Serious skin conditions can present with blisters. Fever, malaise, and epidermal sloughing are signs of a more serious medical condition.

DP 2. Large open and infected blisters can become serious health hazards and should be referred to the AEM for further evaluation and treatment.

TREATMENT PROTOCOL, J-15

MCP for blister on the foot. Wash area with antibacterial soap. Cover a large area of surrounding undamaged skin and the treated blister with a protective dressing of moleskin with a hole in the middle cut out for the blister. An adhesive solution such as tincture of benzoin or a surgical adhesive to the skin around the blister to improve the adhesion of the moleskin. Have the Soldier return to the clinic after the blister ruptures.

MCP for ruptured blisters on the feet. Clean the skin with Betadine. Remove the dead skin with sterile scissors. If sterile instruments are not available or personnel have not been taught to perform the procedure, skip this step. Wash area with Betadine and apply an antibacterial ointment to the blister only. Cover a large area of surrounding undamaged skin and the treated blister with a protective dressing of moleskin between treatments. An adhesive solution such as tincture of benzoin may be applied to the skin around the blister to improve the adhesion of the moleskin. Reevaluate the Soldier every 24 hours.

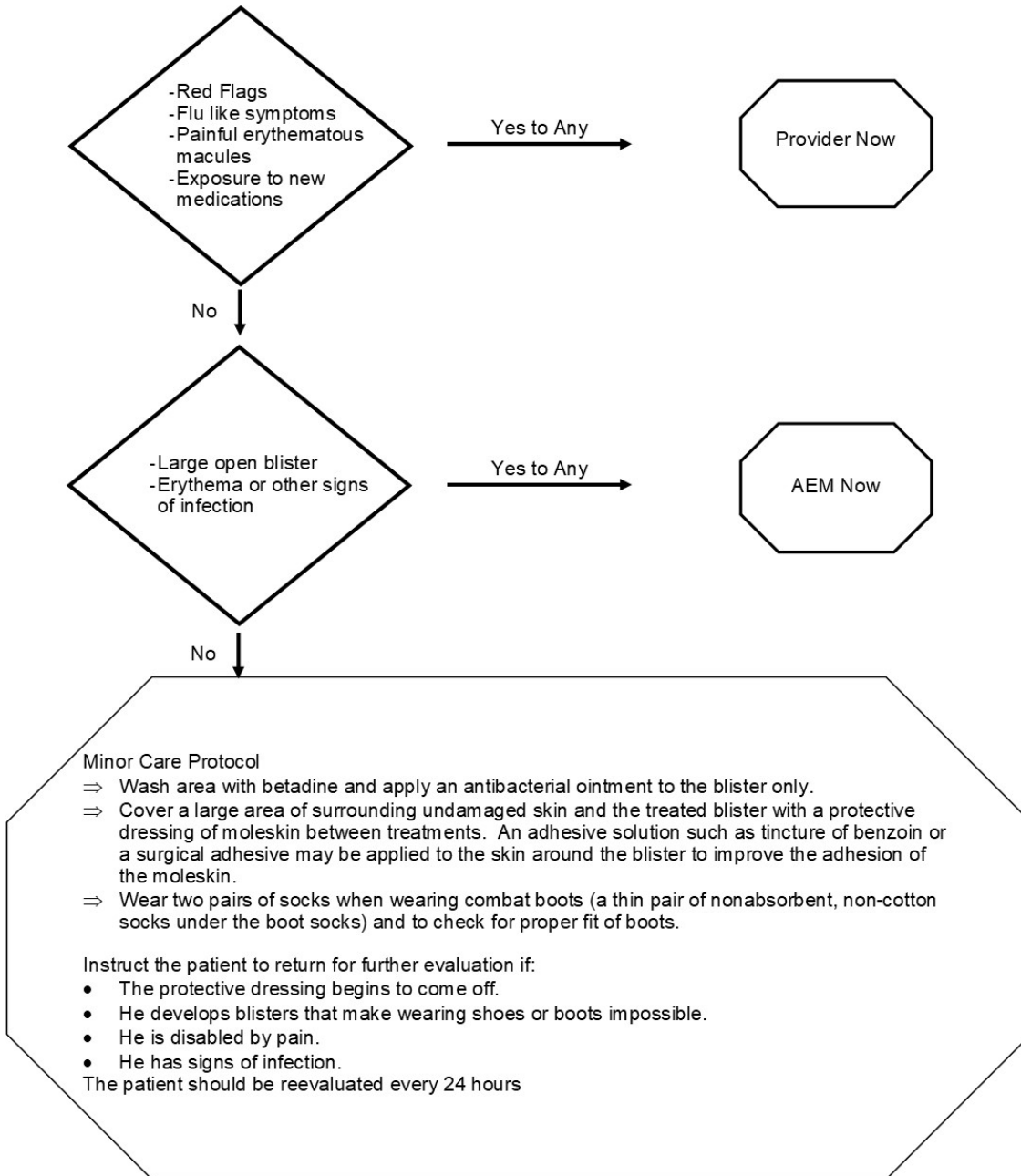
Instruct the Soldier to wear two pairs of socks when wearing combat boots (for example, a thin pair of nonabsorbent, non-cotton socks under the boot socks) and to check for proper fit of boots.

Instruct the Soldier to return for further evaluation if: the protective dressing begins to come off, develops blisters that make wearing shoes or boots difficult, significant pain, or signs of infection develop.

J-15: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
Assists Privileged Provider To Perform Invasive Procedures	pg.68	(5)
Sets Up and Maintains A sterile Field	pg.68	(7)
Perform Wound Care	pg.70	(2)(i)
J-15: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

FRICION BLISTERS ON FEET, J-15

Partial Differential Diagnosis Corn Stephen Johnson Syndrome Staphylococcal scalded skin syndrome	RED FLAGS - Fever/malaise - Epidermal sloughing	Activity Modification: - No running, rucking, or jumping - Walk at own pace/ distance
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CORNS ON FEET, J-16

A callus is a thickened outermost layer of skin from repeated friction or pressure. A corn has a centralized hyperkeratotic area that is often painful on the sole of the foot or toe. Tenderness occurs especially during weight-bearing on the foot.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: No red flags. Diabetes mellitus or a decreased peripheral sensation increases the risk to the Soldier with a peripheral wound; so evaluation and treatment of a corn should be referred to a privileged provider.

DP 2: Plantar warts requires additional treatment. Warts disrupt the normal skin markings so skin lines are not evident and have several dark specks within middle of the wart. One treatment option is using liquid nitrogen to freeze the wart in the clinic. An order from a privileged provider is required prior to treating with liquid nitrogen. Bunions are located on the medial side of the base of the first metacarpal with the big toe deviated inward. Bunions may need to be referred to podiatry.

TREATMENT PROTOCOL, J-16

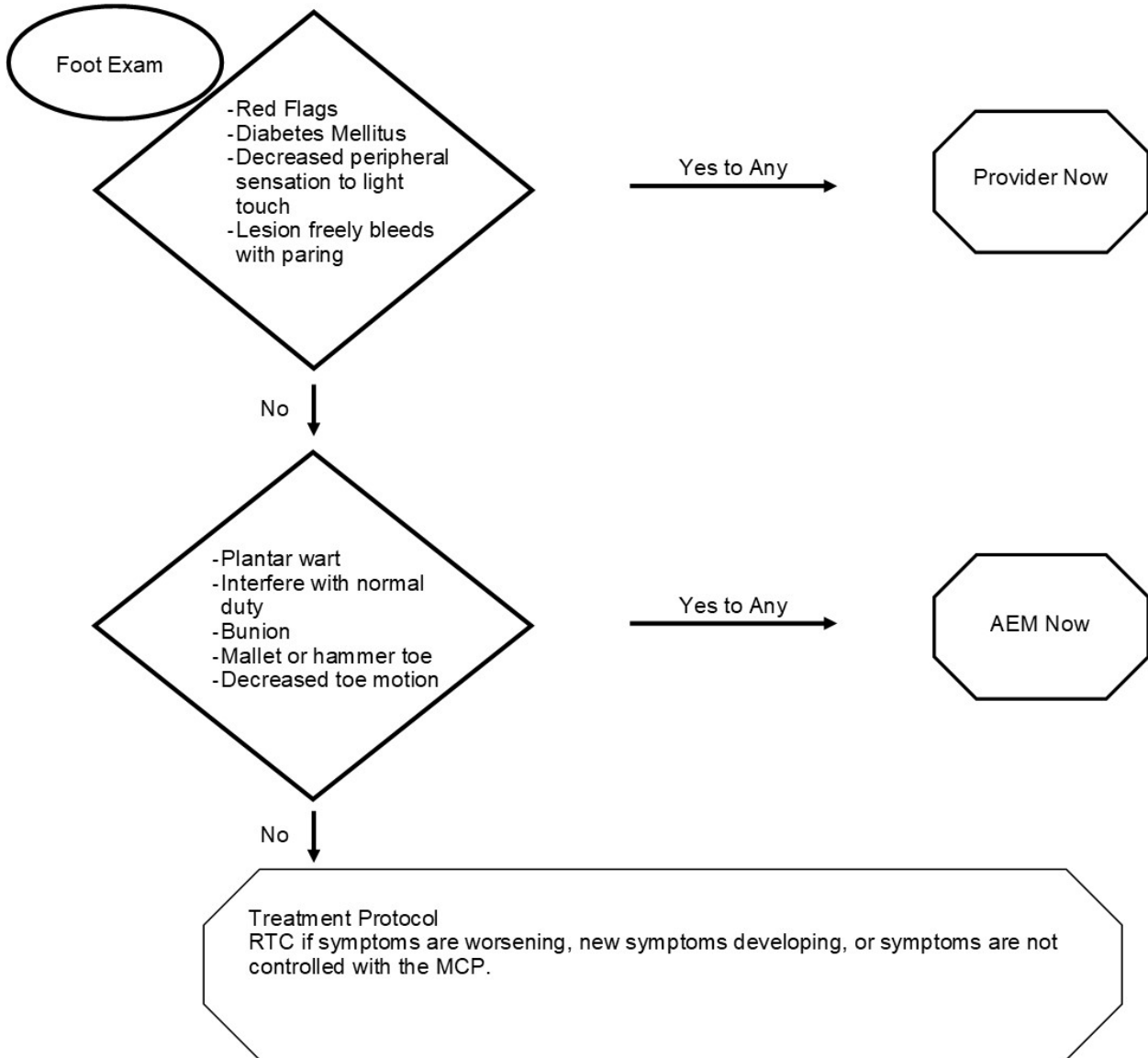
MCP for corns on feet. Soak the Soldier’s foot in warm water for 20 minutes. Paring down a callous/corn: The performing medic must have training in the procedure and have the training documented. After the risks and benefits of the procedure have been explained to the Soldier, Soldier has signed the consent form, and a final timeout has been performed, pare down the callous or corn with a scalpel blade. Reduce the hard skin until the lesion is flexible or the Soldier can stand/bear weight without discomfort. Do not remove skin to the point of bleeding.

Instruct the Soldier on weekly self-debridement. Minor-care can be given using a pumice stone. Refer to AEM if special insole is needed to be constructed for the Soldier’s shoe. Instruct the Soldier to return if the symptoms are worsening, new symptoms develop, or the minor-care protocol does not resolve the symptoms.

J-16: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training and Certifications	pg.68	(k)
Assists Privileged Provider To Perform Invasive Procedures	pg.68	(5)
Sets Up and Maintains A sterile Field	pg.68	(7)
Perform Wound Care	pg.70	(l)
J-16: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125

CORNS ON FEET, J-16

Partial Differential Diagnosis Callus Plantar Wart Corn Bunion	RED FLAGS - None	Activity Modification: - No running, rucking, or jumping - Walk at own pace/ distance
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CUTANEOUS WARTS, J-17

A cutaneous wart is a benign growth of skin caused by a virus. Common and plantar warts often have thrombosed capillaries within them that look like black dots or 'seeds'.

Red Flags. None.

DP 1: Bleeding may indicate that the lesion is something other than a wart and requires further evaluation. Higher risk locations include the face, breast, perineum, anus, and genital regions. Greater than 10 lesions will require multiple repeat visits and other treatment options can be considered. If treatment would limit or prevent the Soldier from conducting an upcoming mission/task, refer to the supervising privileged provider to determine the best timing of treatment. If signs of an infection or inflammation are present around the wart, refer to the supervising privileged provider for treatment.

DP 2: More than three warts will likely require a follow-up visit. AEM should see the Soldier if he or she returns for complications of the wart treatment or a repeat treatment.

TREATMENT PROTOCOL, J-17

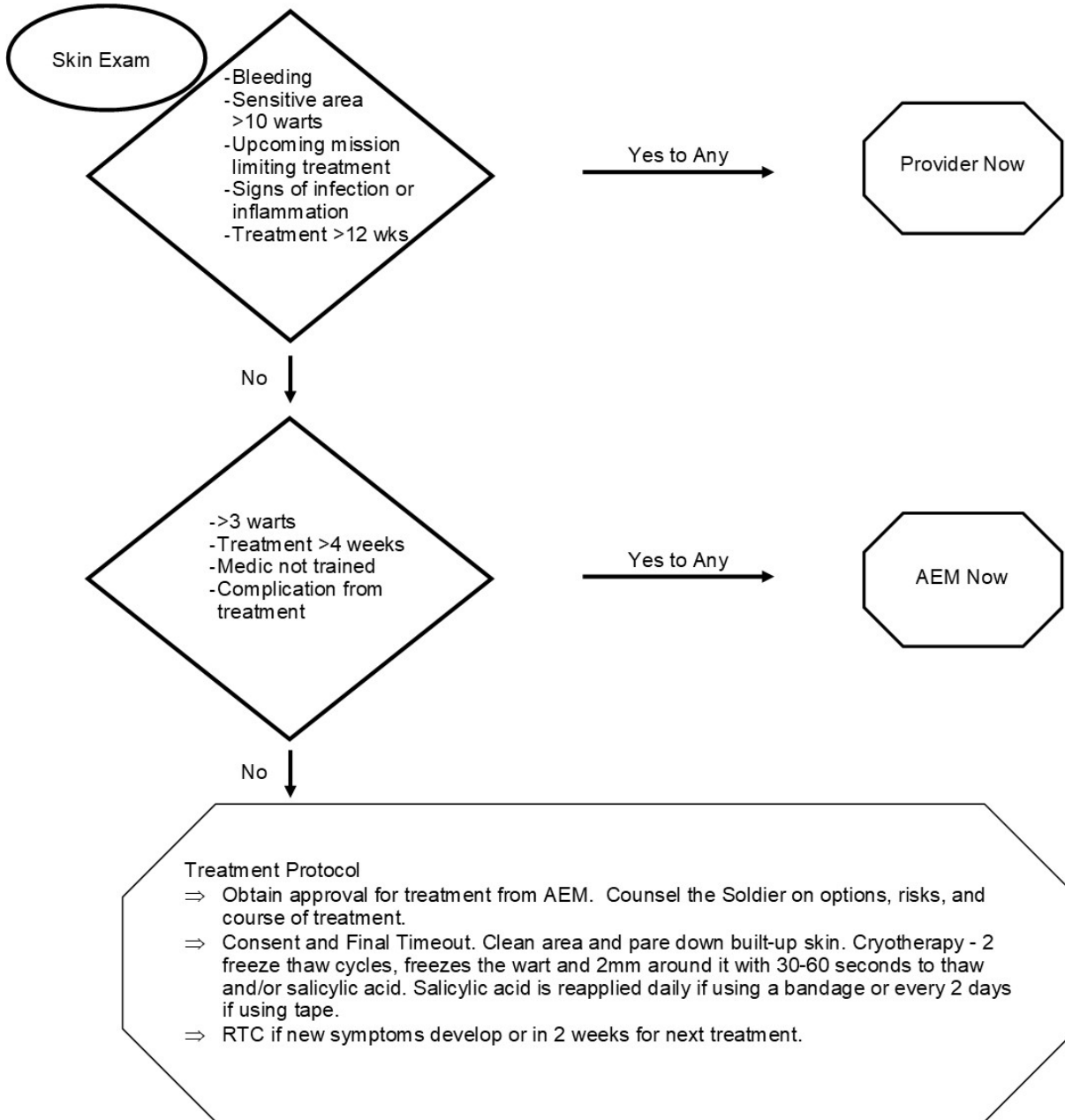
MCP for cutaneous wart. Discuss the Soldier and your treatment plan with the AEM and obtain the supervising privileged provider approval prior to starting treatment. Medic must be trained and have had his or her procedure competency validated prior to performing a procedure. All procedures will be directly supervised.

Discuss the treatment options and their risks, benefits, and alternative that warts will often go away without treatment after several years with the Soldier. After the consent has been obtained and procedure approved by the supervising privileged provider, perform a final timeout. Clean the wart and surrounding skin. Pare down the callous over the wart but not to the point of bleeding or pain. Then apply the treatment option that the Soldier chose. Treatment options include salicylic acid, cryotherapy, or a combination of both. Cryotherapy includes 2 freeze thaw cycles that cover the wart and 2mm around the wart that takes 30-60 seconds to thaw. Instruct the Soldier that a blister, loss of skin pigmentation to the area, and pain may develop over the site. Salicylic acid may be applied to the wart after freezing and covered with a bandage or without freezing and covered with tape. Soldier can reapply salicylic acid and replace the tape or bandage every two days. Soldier should return in two weeks for re-evaluation and retreatment if needed. It is common for warts to require ongoing treatment for up to 12 weeks. Return earlier if new symptoms or complications from the treatment develop.

J-17: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training and Certifications	pg.67	(k)
Assists Privileged Provider To Perform Invasive Procedures	pg.68	(5)
Sets Up and Maintains A Sterile Field	pg.68	(7)
Removes Skin Warts On Extremities As Ordered	pg.68	(14)
Perform Wound Care	pg.70	(l)
J-17: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125

CUTANEOUS WARTS, J-17

Partial Differential Diagnosis Cutaneous Wart Corn Callous Skin Cancer	RED FLAGS - None	Activity Modification: On Foot - No running, rucking, or jumping - Walk at own pace/ distance
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INGROWN TOENAIL, J-18

An ingrown toenail is a nail that extends into the flesh of the toe along its lateral margins (nail fold). It can range from inflammation and tenderness to a significant infection.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Severe lesions are characterized with signs of spreading infection to include red streaks, cellulitis, or ingrown toenails along both nail folds. Red flags, cellulitis, diabetes, and immunocompromised may indicate or increase the risk of a more severe infection requiring antibiotics. Recurrent ingrown toenails need to be evaluated by the supervising privileged provider to determine if permanent nail ablation is required.

DP 2: Moderate lesions are characterized with substantial erythema and pus. Toenail removal (partial or complete) requires an order for the procedure by a privileged provider. Task must be trained, validated, and documented with the competency assessment file for a medic to be able to perform it. After toenail removal (partial or complete), have the Soldier return in three days to evaluate for healing and for spicule reformation with nail regrowth.

TREATMENT PROTOCOL, J-18

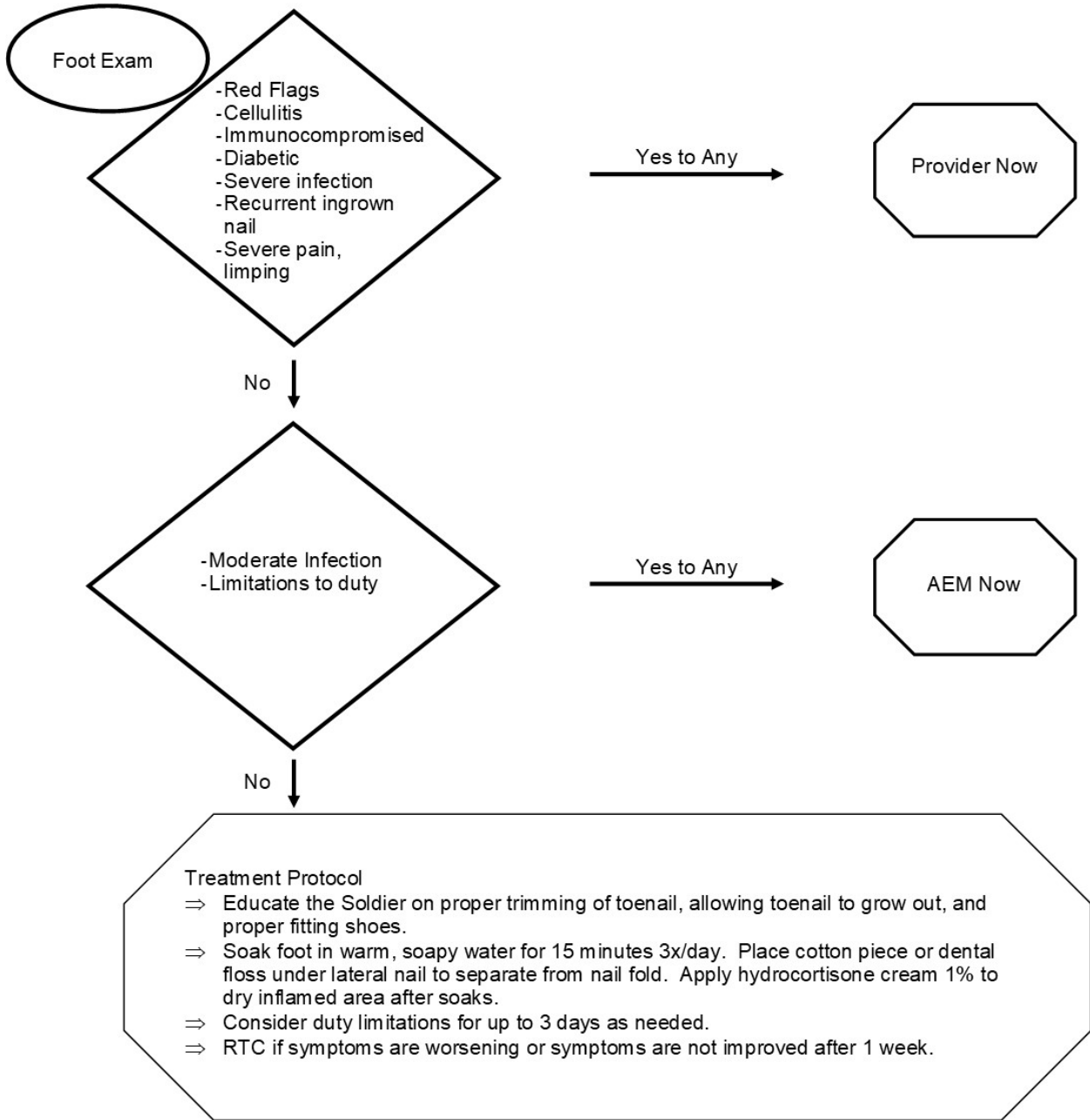
MCP for ingrown toenail. Mild lesions can be treated with conservative measures. Signs include minimal to moderate discomfort, some redness, and no discharge or pus. Educate the Soldier on not cutting the toenail below the lateral fold, allowing the toenail to grow out past the lateral fold before trimming, and importance of well-fitting shoes. Poorly fitting shoes can predispose the Soldier to ingrown toenails. Soak the affected foot in warm, soapy water for 15 minutes three times per day. While the foot is soaking, push the nail fold away from the nail. After soaking and drying the area, place a piece of cotton or dental floss under the lateral edge of the nail to separate it from the nail fold. Hydrocortisone cream 1% can also be applied to the inflamed area after each soaking to further decrease inflammation. Consider duty limitation for up to 3 days as needed.

Return to clinic in one week if still having symptoms or sooner if symptoms are worsening to include spreading or increasing redness, formation of pus or discharge, or increasing discomfort.

J-18: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
All Medication Protocols Associated with 68W Training And Certifications	pg.68	(k)
Assists Privileged Provider To Perform Invasive Procedures	pg.68	(5)
Sets Up and Maintains A sterile Field	pg.68	(7)
Perform Wound Care	pg.70	(l)
Assists With The Administration of Local Anesthesia	pg.70	(r)
Assists In Performing Digital Block Procedures	pg.70	(s)
Perform Toenail Removal	pg.70	(t)

INGROWN TOENAIL, J-18

Partial Differential Diagnosis Paronychia Ingrown Toenail Trauma Cellulitis	RED FLAGS - Red Streaks up Foot - Gangrene - Black Eschar	Activity Modification: - No running, rucking, or jumping - Walk at own pace/ distance
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EXERTIONAL HEAT ILLNESS (HEAT INJURY)/HYPERTHERMIA, K-1 (Heat Cramps, Heat Exhaustion, Heatstroke)

Heat injury results from an excessive loss of water and salt from the body or a breakdown of the body's cooling mechanism. Risks include inadequate acclimatization, illness, blood donation, poor physical fitness, obesity, using drugs such as antihistamines (Benadryl®, Atarax®, CTM®), decongestants (Sudafed®), high Blood Pressure (diuretics, beta blockers) and psychiatrics (tricyclic antidepressants, antipsychotics).

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as "Provider Now." These can be signs of significant underlying medical problems.

DP 1. A "yes" response to any of the questions may indicate heatstroke with a breakdown of the body's heat regulating mechanism. Heatstroke is characterized by high body temperature (>103°F), altered mental status (that is, confusion, delirium, syncope and/or coma) and, in most cases, an absence of sweating. This condition has a high mortality rate and is a MEDICAL EMERGENCY. Lowering the body temperature is the most important treatment. Placing icepacks/ice sheets in the groin, arm pits and behind the neck, along with ice sheers under and on top the Soldier allows for rapid cooling. An alternative is dousing the Soldier with water and gently fanning to allow for evaporative cooling. Start an intravenous infusion. Monitor the Soldier's body (rectal) temperature. Transport to an emergency treatment location, if available.

DP 2. A "yes" response to questions may indicate heat exhaustion which occurs as a result of an excessive loss of water and salt from the body. The syndrome is characterized by profuse perspiration, pallor, and perhaps low blood pressure. The mortality rate from this disorder, if treated, is extremely low. Moving the Soldier to a cool area for rest and the administration of fluids (orally or intravenous infusion, depending on severity of symptoms) will result in prompt recovery. Untreated heat exhaustion may progress to heatstroke.

DP 3. A "yes" response to these questions indicates heat cramps. These are painful cramps of voluntary muscles which result from excessive loss of salt from the body. Muscles of the extremities and the abdominal wall are usually involved. Body temperature is normal. Heat cramps can be promptly relieved by replacing salt and fluid orally and placing the individual in a cool environment.

TREATMENT PROTOCOL, K-1

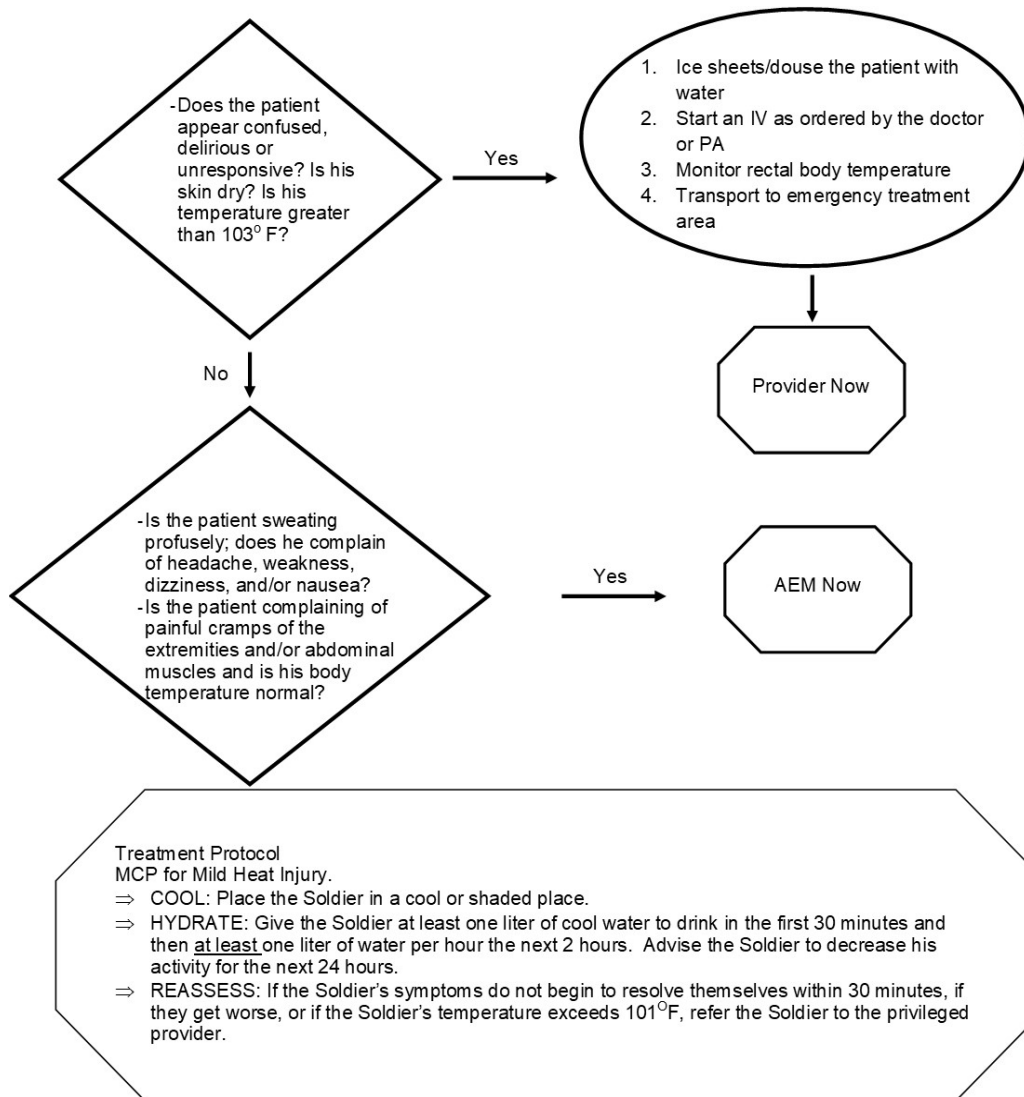
MCP for mild heat injury. COOL: Place the Soldier in a cool or shaded place. HYDRATE: Give the Soldier at least one liter of cool water to drink in the first 30 minutes and then at least one liter of water per hour the next 2 hours. Advise the Soldier to decrease his activity for the next 24 hours. REASSESS: If the Soldier's symptoms do not begin to resolve themselves within 30 minutes, if they get worse, or if the Soldier's temperature exceeds 100.3°F, refer the Soldier to the supervising privileged provider.

K-1: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training And Certifications	pg.68	(k)
Initiate an Intravenous Infusion	pg.69	(2)(a)
Assists In The Initial Treatment Of Environmental Injuries	pg.69	(2)(e)

K-1: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 11: Force Health Protection	Initiate Treatment for a Heat Injury	081-833-0038

HEAT INJURY/HYPERTHERMIA, K-1 (Heat Cramps, Heat Exhaustion, Heatstroke)

Partial Differential Diagnosis Heatstroke Heat Cramps Heat Exhaustion Fever/ Infection Dehydration Hyperthyroidism	RED FLAGS - Altered mental status - Abnormal vital signs	Activity Modification: - No significant exercise x 48 hours - Limit exposure to hot environments
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HYPOTHERMIA, K-2

Hypothermia, or a lower than normal body temperature, can be the result of heat loss from exposure to cold or wet environments, inadequate heat production due to poor nutrition or exhaustion, or inaccurate heat regulation from using drugs such as nicotine, alcohol, and medications with anticholinergic side effects.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

IMPORTANT INFORMATION ON THE PROTOCOL

DP 1. Mild hypothermia presents with T 90-95°F, normal mental status, tachycardia, tachypnea, and shivering. Moderate hypothermia presents with T 82-90°F, lethargy, bradycardia with arrhythmias, and hypoventilation without shivering. Severe hypothermia presents with T <82°F, coma, asystole, and apnea so that the Soldier may appear dead but resuscitation is still possible. Note any discrepancy between the extent of an abnormal vital sign and the degree of hypothermia may represent an underlying alternate cause for the vital sign abnormality like a head injury for confusion or hypovolemia for tachycardia. Frostbite may appear white or grayish-yellow and be hard or waxy to the touch. Support the Soldier’s airway, breathing, circulation, start two large bore IVs with warmed fluids, remove wet clothes, use body heat, blankets, and space/hypothermia blanket to rewarm, and transport horizontally. Low exertion of peripheral muscles can result in further drop in temperature.

DP 2. Symptoms of hypothermia with a normal temperature suggests an alternative diagnosis. Opioids, behavioral health medications, and alcohol can include medications for anxiety, depression, antipsychotics can impair thermoregulation. Severe pain associated with a nonfreezing cold injury requires further evaluation and management.

DP 3. See Protocol K-3 for immersion foot. Immersion foot usually results when the skin is exposed to wet, cold foot gear or from immersion at temperatures from 32°F to 59°F for over two to three days (nonfreezing cold injury (NFCI) or immersion foot) and presents with a white, wrinkled, numb, painless extremity.

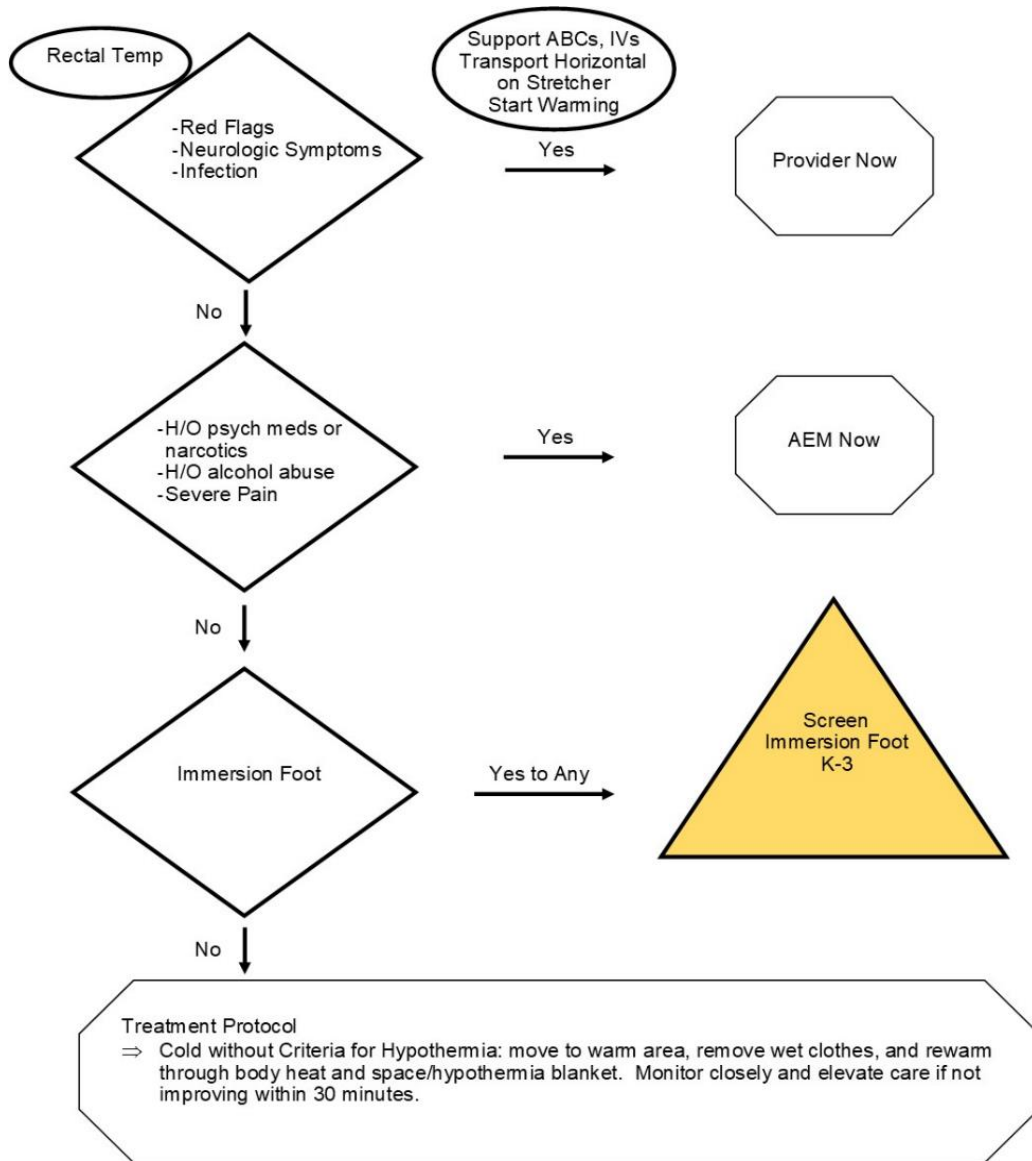
TREATMENT PROTOCOL, K-3

Move Soldier to warm area. Remove wet clothing. Rewarm through utilizing body heat and space/hypothermia blanket. Do not place numb area by heat source (risk of burns).

K-2: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training and Certifications	pg.68	(k)
Initiate an Intravenous Infusion	pg.69	(2)(a)
Identifies, reports and Treats Hypovolemia	pg.69	(2)(c)
Assists In The Initial Treatment Of Environmental Injuries	pg.69	(2)(e)
K-2: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 11: Force Health Protection	Treat a Casualty for a Cold Injury	081-833-0039

HYPOTHERMIA, K-2

Partial Differential Diagnosis Environmental Exposure Exhaustion and Malnutrition Hypothyroidism Sepsis	RED FLAGS - T<96 degrees F - Altered Mental Status - Abnormal Vital Signs - Frostbite - Trauma	Activity Modification: - Limit exposure to cold environments
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IMMERSION FOOT, K-3

Immersion foot usually results when the skin is exposed to wet, cold foot gear or from immersion at temperatures from 32°F to 59°F for over 2-3 days NFI or immersion foot. NFI can result in an infection acutely or cold intolerance and pain syndromes chronically. Prolonged exposure to wet environments at temperatures greater than 59°F (jungle foot) can also result in acute pain or injury but typically do not cause chronic issues. Presentation is with a white, wrinkled, numb, painless extremity. After warmed, it becomes a mottled pale blue with delayed capillary refill and start of swelling (hours to days). Progresses to a red, swollen painful extremity with blisters in areas of tissue damage (days to weeks). Can remain sensitive to cold, painful to cold, cool to touch, excessive sweating, or painful for weeks to years.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Frostbite, hypothermia, and signs of gangrene represent a serious medical condition that requires prompt treatment. Severe pain or signs of an infection (such as, fever, red streaks, or swollen glands) require further evaluation by a privileged provider. Hypothermia should be rewarmed once the Soldier is under shelter and able to stay warm. Do Not rub the extremity. Do Not rewarm the extremity in NFI unless frostbite is also present. During the exam, it is important to look for other injuries, especially in the setting of trauma.

DP 2: Symptoms lasting longer than one week will need a more in depth evaluation. If the Soldier is unable to perform duties, a profile for one week may initially be required.

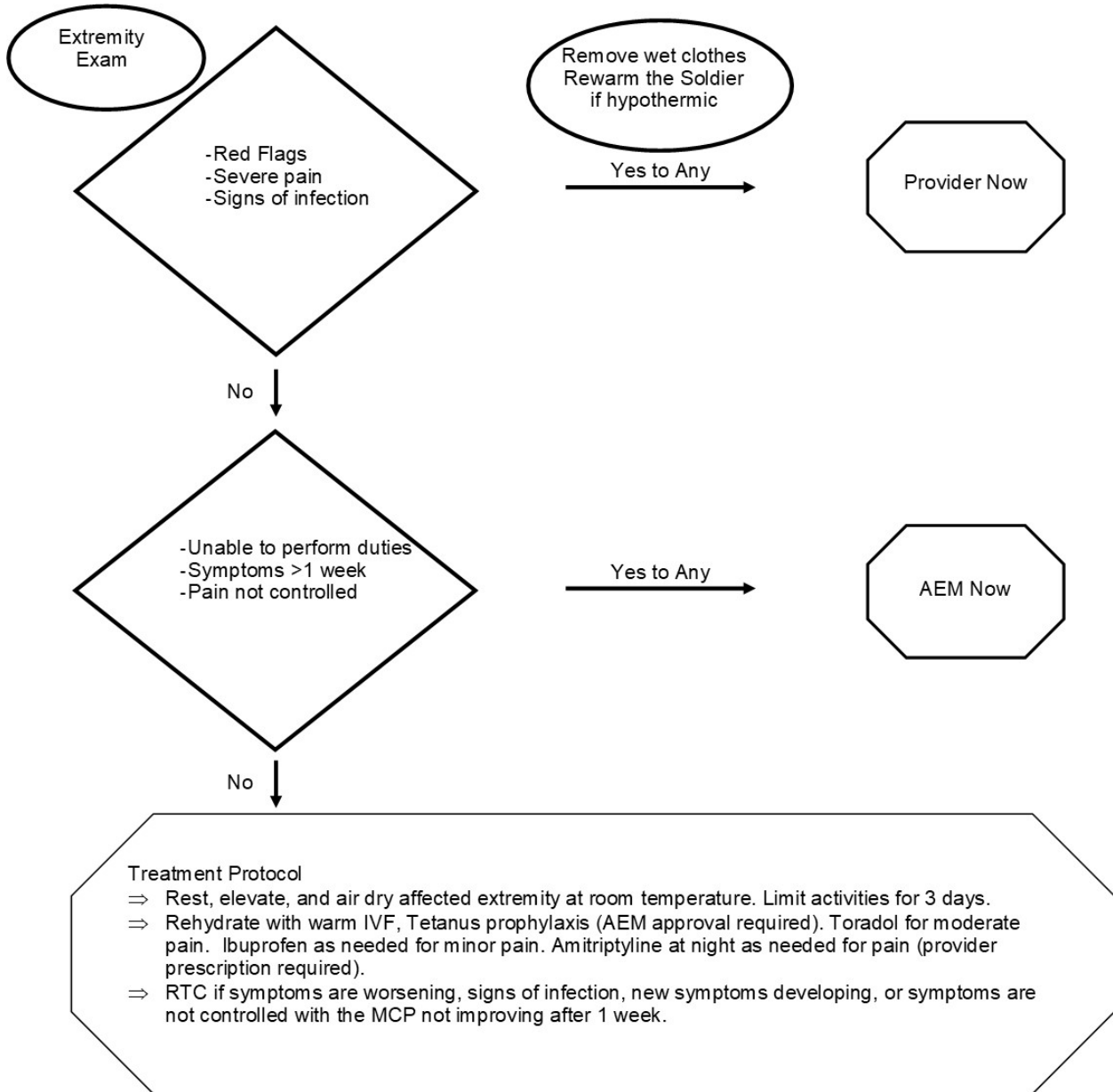
TREATMENT PROTOCOL, K-3

MCP for immersion foot. Rewarm the extremity gradually with bed rest, elevation of the extremity, and air drying at room temperature. Rapid warming can increase pain, swelling, and risk of further injury in the extremity. Limit activities with affected extremity and keep elevated for three days. Soldier may have a “slapping, flat footed” gait upon starting to walk that should improve within a week. Rehydrate with warm IV fluids and provide tetanus prophylaxis if required (discuss with AEM prior to giving). Ibuprofen, amitriptyline (requires a privileged provider prescription) as needed for pain. A fan to cool the affected extremity can also help with the pain. Refer to AEM if pain is not controlled. Return to clinic if new symptoms develop, condition worsens, signs of infection.

K-3: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training and Certifications	pg.68	(k)
Initiate An Intravenous Infusion	pg.69	(2)(a)
Identifies, Reports And Treats Hypovolemia	pg.69	(2)(c)
Assists In The Initial Treatment Of Environmental Injuries	pg.69	(2)(e)
K-3: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 11: Force Health Protection	Treat a Casualty for a Cold Injury	081-833-0039

IMMERSION FOOT, K-3

Partial Differential Diagnosis: Nonfreezing Cold Injury Cold Urticaria Raynaud Phenomenon Frostbite	RED FLAGS - Gangrene/Necrosis - Hemorrhagic Blisters - Hypothermia - Frostbite - Trauma	Activity Modification: -Limit activities for 3 days -Elevate affected extremity x 3 days
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CHAPPED SKIN/WINDBURN, K-4

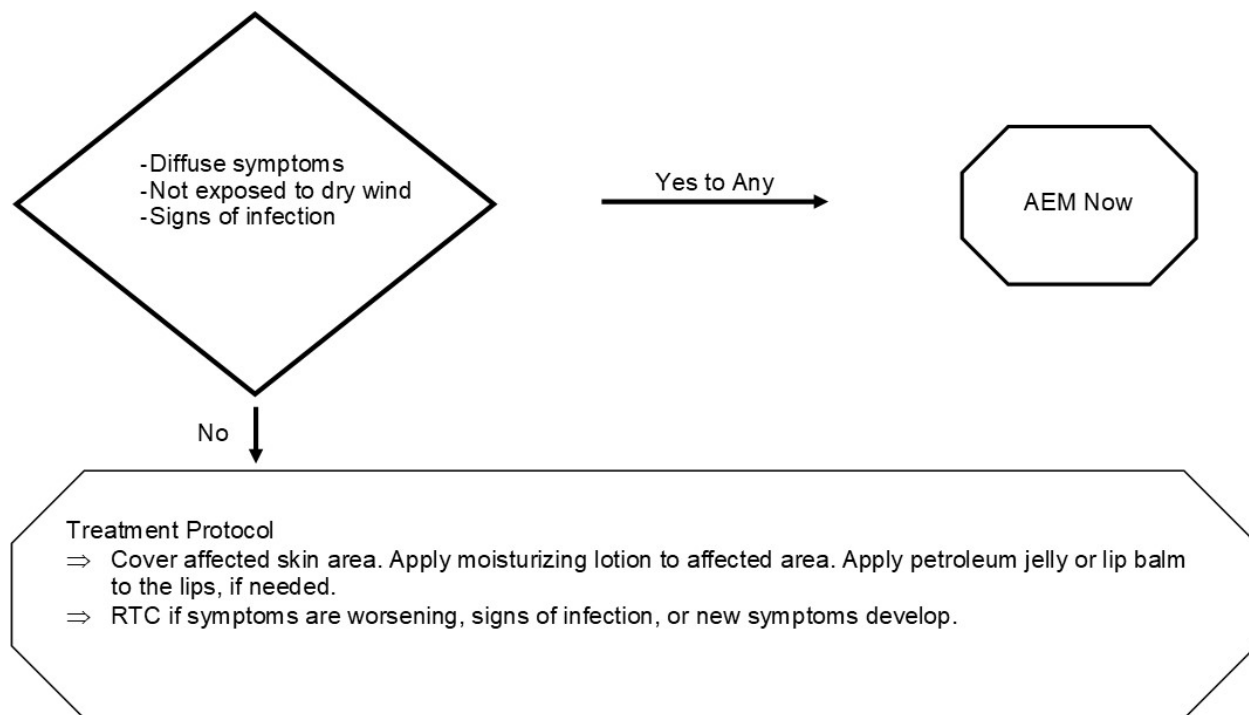
Chapping is the unusually rapid drying of skin due to exposure to a hot or cold dry wind which draws water out of the skin. Generally, it is not a medical problem unless cracking or fissuring with a secondary infection takes place. The involved skin heals as new skin cells develop.

DP 1: Since exposure to dry wind causes chapping, involvement of areas other than the hands and face or not being exposed to dry wind makes this diagnosis unlikely, and the Soldier should be referred for further evaluation. Presence of inflammation other than simple skin redness warns of the possibility of infection and requires evaluation for possible antibiotics. Numbness can be a sign of a cold injury.

TREATMENT PROTOCOL, K-4

MCP for chapped skin. Cover the exposed area so that it is no longer exposed to the drying wind. Apply moisturizing lotion (oil based cream or ointment). Apply Vaseline or lip balm to the lips. Moisturizing cream can also protect from further wind effects.

K-4: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training And Certifications	pg.68	(k)
Assists In The Initial Treatment Of Environmental Injuries	pg.69	(2)(e)



FROSTBITE, K-5

Frostbite results from the skin (usually on the toes, fingers, or face) being exposed to extreme cold for an extended period of time. Lower temperatures and high winds result in shorter times to injury. Immediate evaluation is required.

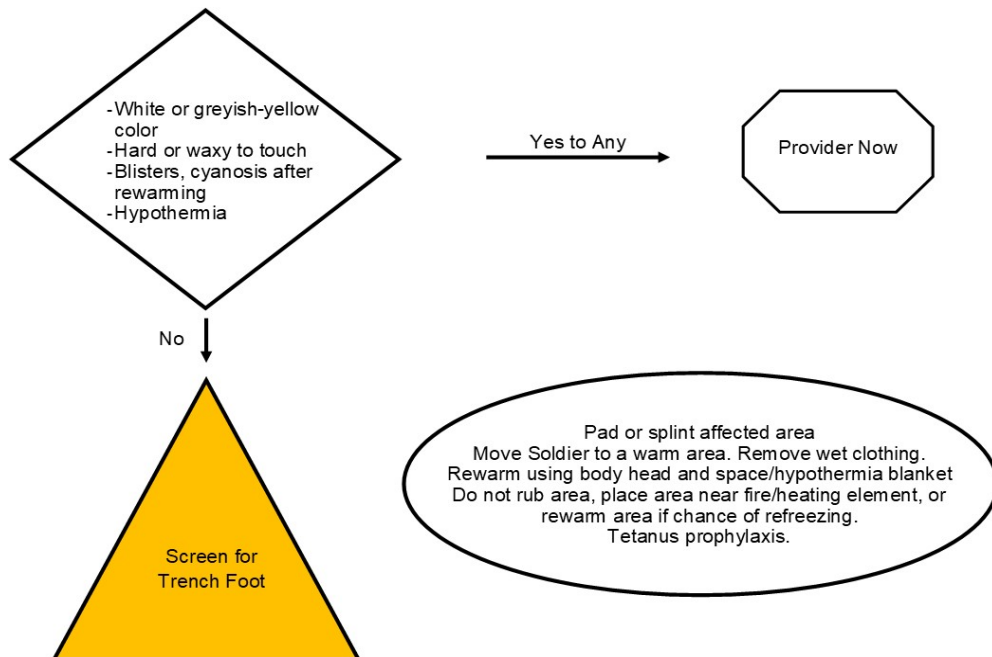
DP 1: Presentation includes complaints of a cold, numb, and clumsy affected area. Area may appear white or grayish-yellow and be hard or waxy to the touch. Blisters or cyanosis will be present after rewarming.

DP 2: If not hypothermia or frostbite, screen for trench foot (algorithm K-3).

TREATMENT PROTOCOL, K-5

MCP initial frostbite treatment. Pad or splint the affected area. Avoid walking/standing on frostbitten feet. If walking required for evacuation, do not rewarm prior to walking. Move Soldier to warm area. Remove wet clothing. Do not rewarm frostbitten area if there is a possibility of the area refreezing. Rewarm with placing area in warm water or body heat and space/hypothermia blanket. Do not place frostbitten area by heat source (risk of burns with sensory loss) or rub the frostbitten area.

K-5: In accordance with MEDCOM Regulation 40-50		
Applies Splints	pg.68	(12)
Identifies, Reports And Treats Hypovolemia	pg.69	(2)(c)
Assists In The Initial Treatment Of Environmental Injuries	pg.69	(2)(e)
K-5: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 11: Force Health Protection	Treat a Casualty for a Cold Injury	081-833-0039



CRABS/LICE (PEDICULOSIS), K-6

Crabs/lice are tiny insects that are visible to the naked eye that infest the hairy areas of the body (such as, groin, body hair, and scalp). The insect deposits eggs (nits) and attaches them at the bases of hair shafts. The lice require a diet of human blood and will die within three days after removal from the body. The possibility of spreading infection to close associates by intimate contact or common use of clothing, beds, or toilet articles is real.

DP 1: Secondary infection is common due associated itching. If nits and lice are not seen, then further evaluation is needed for a different diagnosis (contact dermatitis or scabies).

TREATMENT PROTOCOL, K-6

MCP for lice. Wash clothes, sleeping linens, sleeping bag in hot water (above 149°F) or have them dry cleaned. If unable to wash or dry clean, place in a sealed bag for two weeks.

MCP for body lice. Lice live on the seams of the clothing. Permethrin 5% application can also be used in addition to laundering the clothes.

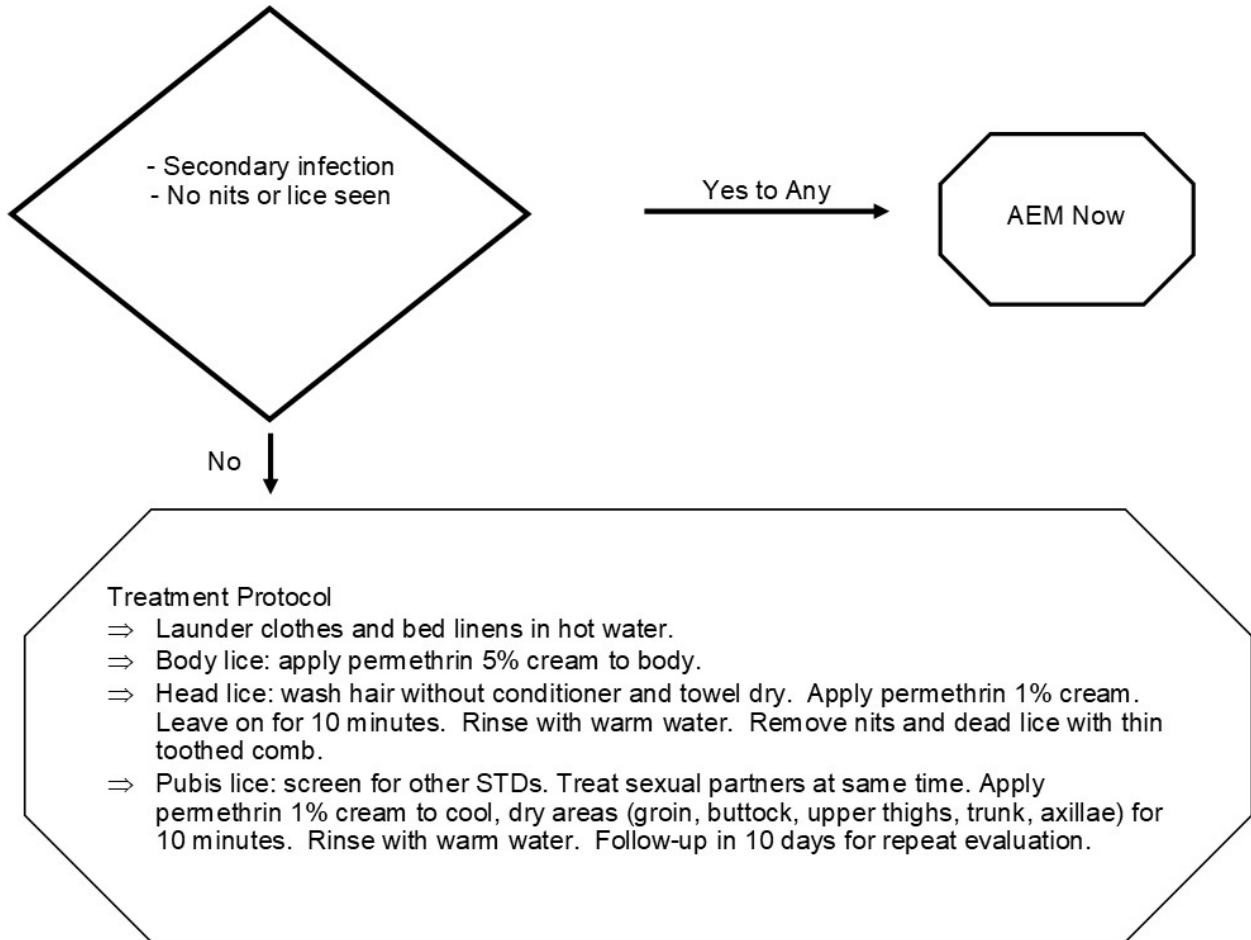
MCP for head lice. Wash the area without using conditioner and towel dry. Apply permethrin cream to saturate the affected area. Leave on for 10 minutes. Rinse with warm (not hot) water. Use a close toothed comb to remove nits (eggs from base of hair follicles). Repeat in one week if nits or lice are still present.

MCP for pubis lice (such as, crabs). Screen for other STIs. Treat recent sexual contacts at the same time. Skin should be cool and dry. Apply Permethrin cream to all affected areas (groin, buttock, thighs, trunk, and axillae) for 10 minutes and then rinse off in warm water. Remove nits with tweezers or thin toothed comb. Follow-up in 10 days. If unable to follow-up, retreat with Permethrin cream in 10 days due to 40% of Soldiers not having cleared the infection with one treatment.

K-6: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
All Medication Protocols Associated with 68W Training And Certifications	pg.68	(k)
K-6: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 6: Primary Care	Treat Skin Disorders	081-833-0125
Subject Area 18: Medication Administration	Administer Topical Medications	081-833-3020

CRABS/LICE (PEDICULOSIS), K-6

Partial Differential Diagnosis: Lice Scabies Contact Dermatitis Fungal Infection Hair Casts	RED FLAGS -None	Activity Modification: None
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INSECT BITES (NOT CRABS/LICE), K-7

Insect bites are characterized by itching, local swelling, mild pain, and redness. All of these reactions represent a local reaction to the sting of the insect. Document any history of tick bites and include the location of the bite.

Red Flags. Wheezing, shortness of breath: immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Red flags, hives, or history of severe reaction from similar insect bite (such as, bee sting allergy), have Soldier inject epinephrine pen if indicated (signs of respiratory or circulatory compromise) and refer to a privileged provider immediately. Reported poisonous insect bite (brown recluse, black widow, etc.) should also be immediately referred.

DP 2: If no signs of an insect bite can be seen, a blister or ulcer is present, or there is moderate to severe pain, refer to the AEM for further evaluation because it may be something other than an insect bite.

TREATMENT PROTOCOL, K-7

MCP for Insect Bite. Remove any stinger, head of tick, or other biting apparatus left at the bite site. Clean with betadine solution.

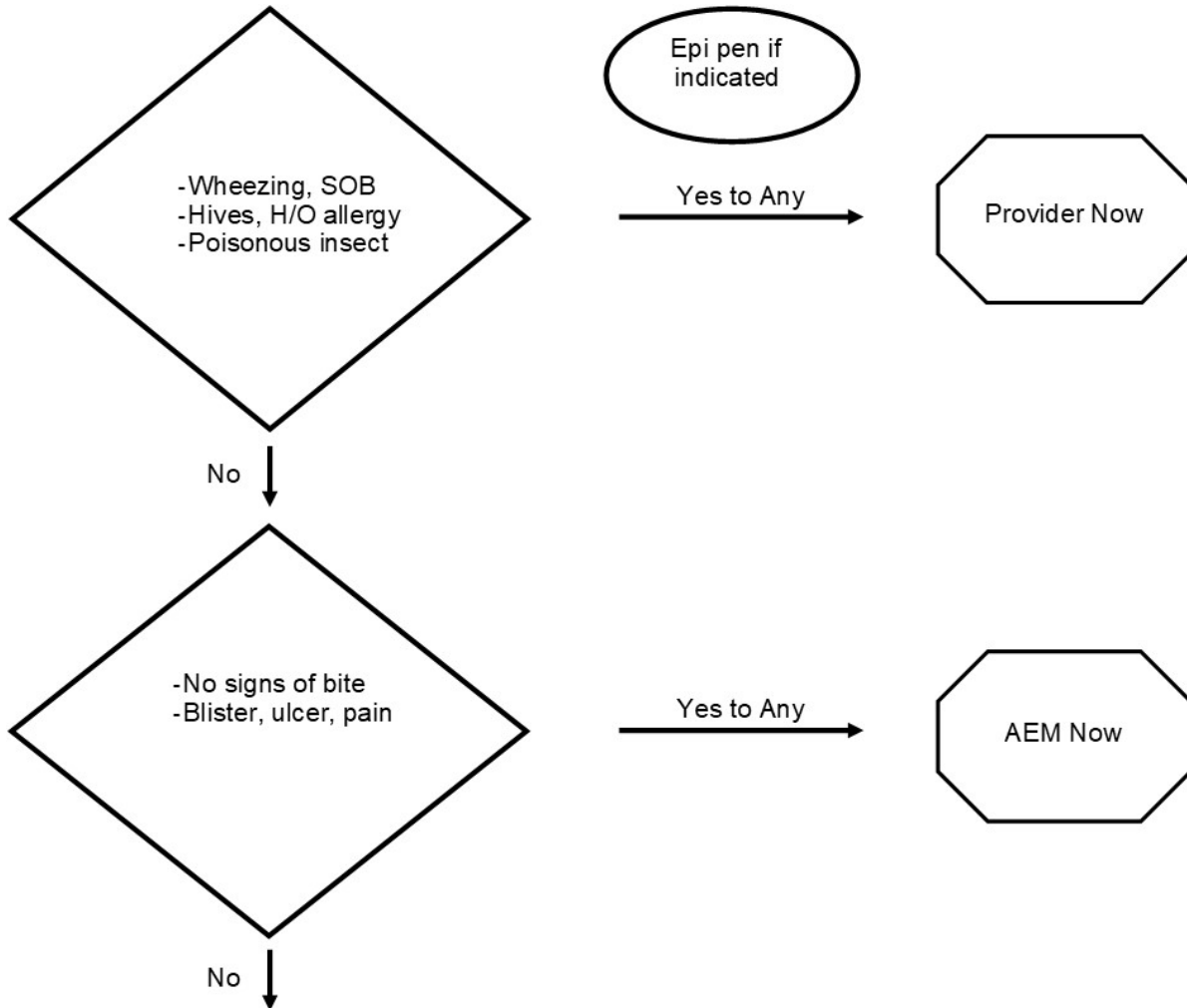
Apply Calamine lotion or hydrocortisone 1% cream four times per day as needed for itching. Apply cold compress or ice pack as needed for swelling.

Return to clinic if symptoms worsen, new symptoms develop, or symptoms are not improving within 48 hours.

K-7: In accordance with MEDCOM Regulation 40-50		
Administer Topical Ointment/Lotions	pg.67	(3)(a)
All Medication Protocols Associated with 68W Training And Certifications	pg.68	(k)
K-7: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 11: Force Health Protection	Treat a Casualty for a Cold Injury	081-833-0039

INSECT BITES (NOT CRABS/LICE), K-7

Partial Differential Diagnosis: Insect Bite Skin Infection Contact Dermatitis	RED FLAGS -Swelling of Lips or Tongue -Trouble Breathing -Abnormal Vital Signs	Activity Modification: None
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Treatment Protocol

- ⇒ Remove any stinger, head of tick, or other biting apparatus. Clean site with betadine solution.
- ⇒ Apply calamine lotion or hydrocortisone 1% cream every 6 hours as needed for itching. Apply an ice pack as needed for swelling.
- ⇒ RTC if symptoms worsen, new symptoms develop, or symptoms are not improving within 48 hours.

EXPOSED TO HEPATITIS or HIV, L-1

This protocol is to be used in locations where a local policy is not already in place for the screening of potential HIV or Hepatitis exposures.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Known or high risk contacts for HIV should be offered prophylaxis medications to decrease the risk of infection if they had non-intact skin, mucous membrane, blood, or at risk body fluid exposures. Prophylaxis medications should be started within 2 hours of initial exposure but no later than 72 hours. With Hepatitis B, immunoglobulin should be provided within 24 hours of exposure but no later than 1 week. With Hepatitis C, post exposure management is with early detection and treatment of an infection.

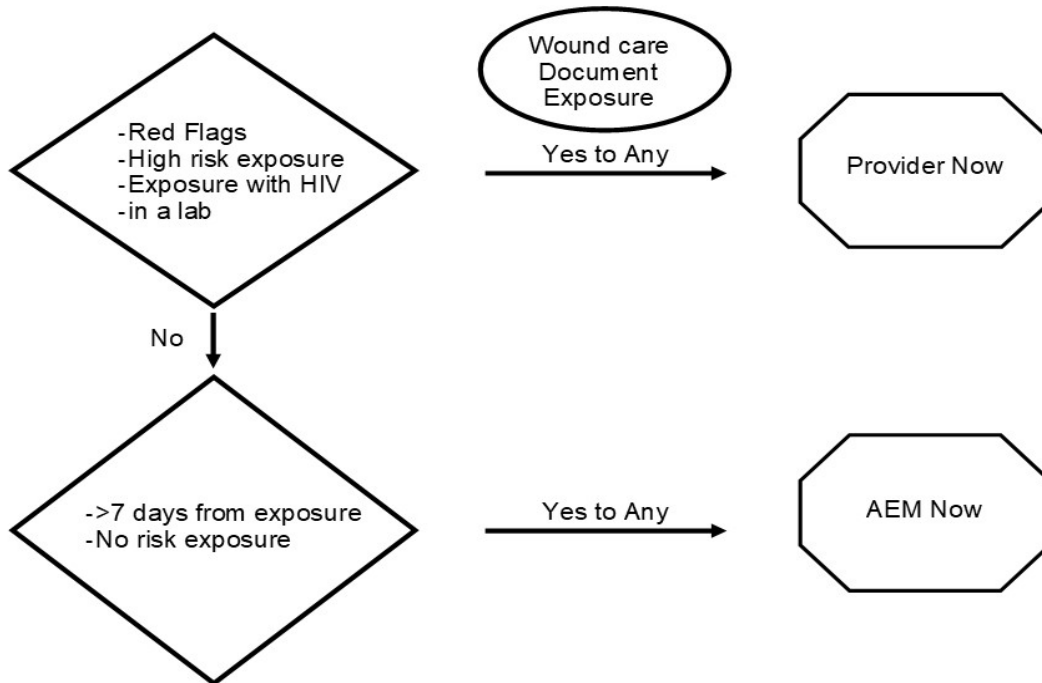
DP 2: Feces, nasal secretions, saliva, gastric secretions, sputum, sweat, tears, and urine are not considered to be infectious without blood being present within them. Intact skin is a successful barrier to potentially infectious fluid. Note that cuts, abrasions, dermatitis are not considered intact skin. These exposures should be referred to the AEM for counseling and referral to a privileged provider if needed. Exposures that are over 7 days old are no longer within the window for prophylaxis treatment. They should be referred to the AEM for counseling and required laboratory testing.

TREATMENT PROTOCOL, L-1

MCP for Initial Treatment of Exposure. For Soldiers who are exposed to blood or body fluids through a wound or mucous membrane, wash the area with soap and water or flush the mucous membranes with saline or water. Clean any wounds with an alcohol-based hand hygiene agent. Alcohol helps kills the HIV virus. Document the exposure with: source person and Soldier risk factors, serologic tests (HIV, Hepatitis B, Hepatitis C), type of exposure to include instrument (hollow bore needle, scalpel if indicated), time of incident, body fluid involved, body location of exposure to include depth of wound, and contact time with contaminated fluid. If the source person is known to be infected, it is important to determine the person’s most recent viral load and previous treatment to include drug resistance.

EXPOSED TO HEPATITIS B, Hepatitis C, or HIV, L-1

Partial Differential Diagnosis: -Low Risk Exposure -High Risk Exposure	RED FLAGS - Known Infection - High Risk Contact	Activity Modification: -None
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Ensure the following information is documented in the Healthcare record before the patient leaves:

HCP – The following information should be obtained from the injured HCP and verified from their medical/occupational health record:

- Dates of HepB immunizations
- Post-immunization titer, if known
- Previous testing (if available) for HBV and HCV
- Tetanus immunization status
- Current medications
- Current or underlying medical conditions that might influence use of/response to vaccination

Exposure – The following information regarding the exposure should be obtained:

- The date and time of the exposure
- Nature of the exposure (i.e., non-intact skin, mucosal, percutaneous, human bite)
- Type of fluid (i.e., blood, blood contaminated fluid, or other contaminated fluid)
- Body location of the exposure and contact time with the contaminated fluid
- For percutaneous injuries, a description of the injury (e.g., depth of wound, solid versus hollow needle, sharp use in source patient)

DENTAL PROBLEMS, L-2

Problems with the teeth are usually self-evident. Symptom of dental pain may be a result of a non-dental source such as myofascial inflammation, migraine headache, maxillary sinusitis, ear issues, temporomandibular joint pain, or nerve pain. Always inquire about other complaints before referring the Soldier to a dentist.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Exposed pulp (that is, feathery material in middle of tooth), knocked out tooth with tooth present, severe pain, signs of oral infection (such as, redness, gum bleeding, swelling) should be referred to the dentist. Trauma with associated jaw pain, sinus problems with tooth pain, heart symptoms with jaw pain (such as, shortness of breath, sweating, lightheaded, chest pain/pressure), signs of face infection, or if the dentist is not available should be referred to the supervising privileged provider.

DP 2: AEM can provide temporary pain medications and treatment for a broken tooth (pulp is not showing). Jaw pain not from trauma can be further evaluated by the AEM for temporomandibular joint dysfunction or infection.

TREATMENT PROTOCOL, L-2

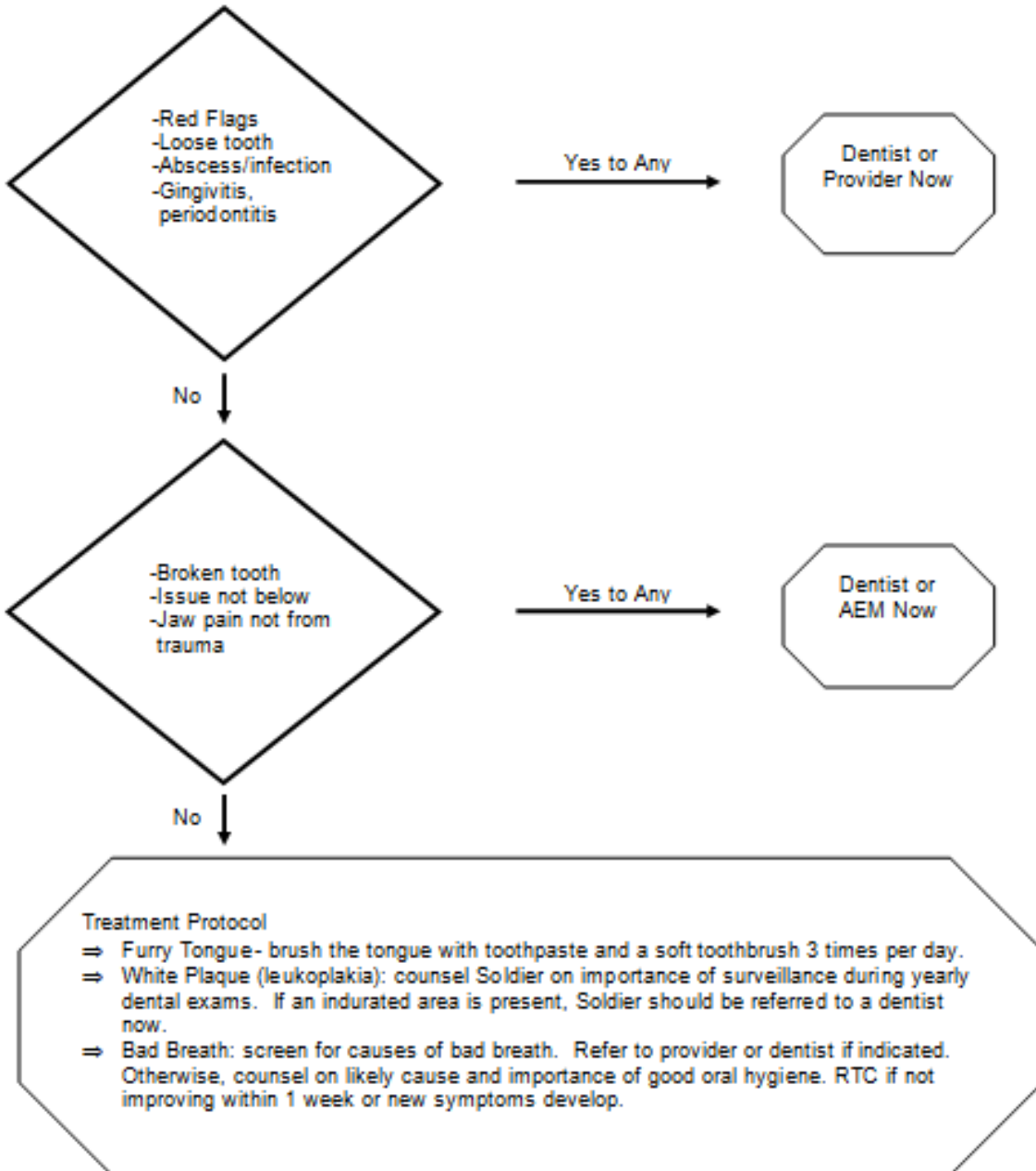
MCP for furry tongue. Benign condition often due to antibiotic use, tobacco use or poor oral hygiene. Treatment is to brush the area with toothpaste and a soft toothbrush three times per day. White patches on the oral mucosa (leukoplakia) is a benign condition often due to smokeless tobacco use or mechanical irritation (such as, braces, chewing). Instruct on importance of surveillance during dental visits, because there is a risk that it could progress to cancer over the next 10 years. If an area is indurated, refer to a dentist now to be evaluated to determine if a biopsy is necessary.

MCP for bad breath. Mostly commonly from poor oral hygiene and caused by bacteria on material between the teeth and on the back third of the tongue. It can also be related to eating certain types of food/ beverages, smoking, low saliva flow states (such as, sleeping, dry mouth), or infection/inflammation (such as, tonsils, sinuses, bronchitis). After obtaining a history, refer to a PCC or dentist, if indicated. Otherwise, instruct on the likely cause and importance of proper oral hygiene with brushing three times per day and flossing daily. Return to clinic if symptoms are not improving within one week or additional symptoms develop.

L-2: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training And Certifications	pg.68	(k)

DENTAL PROBLEMS, L-2

Partial Differential Diagnosis: Tooth Cavity Poor Dental Hygiene Temporomandibular Joint Pain Infection Heart Attack	RED FLAGS - Exposed Pulp - Avulsed Tooth - Severe Pain - Trauma - Chest Pain, SOB	Activity Modification: None
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SORES IN THE MOUTH, L-3

Sores in the mouth are usually inflammatory or ulcerative in nature and may be associated with many upper respiratory infections or may result from trauma. Refer Soldiers with sores in the mouth to Category III care.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Diffuse lesions can be a sign of an inflammatory disorder (such as, Stevens-Johnson syndrome, erythema multiforme). Painless lesion can be a sign of Lupus. Lesions within the mouth and groin can represent Behcet’s syndrome. Mouth sores can be a sign of Crohn’s Disease requiring further evaluation by the supervising privileged provider. Lesions that have been present for over two weeks need further evaluation to rule out other causes.

DP 2: Herpes Simplex and Herpes Zoster can both presents as a cluster of ulcers. When it is within the mouth, refer the Soldier to the AEM for further evaluation. Large oral ulcers could be from other causes or require additional treatment.

TREATMENT PROTOCOL, L-3

MCP for aphthous ulcer (canker sore). Most common oral ulcer. They present as small, painful, shallow, round or oval oral ulcers with a grayish base. Apply ¼ inch of triamcinolone oral paste to the ulcer at bedtime. It should resolve 10-14 days. Refer to the supervising privileged 3.0 if there is a history of severe stomach pain or bloody diarrhea.

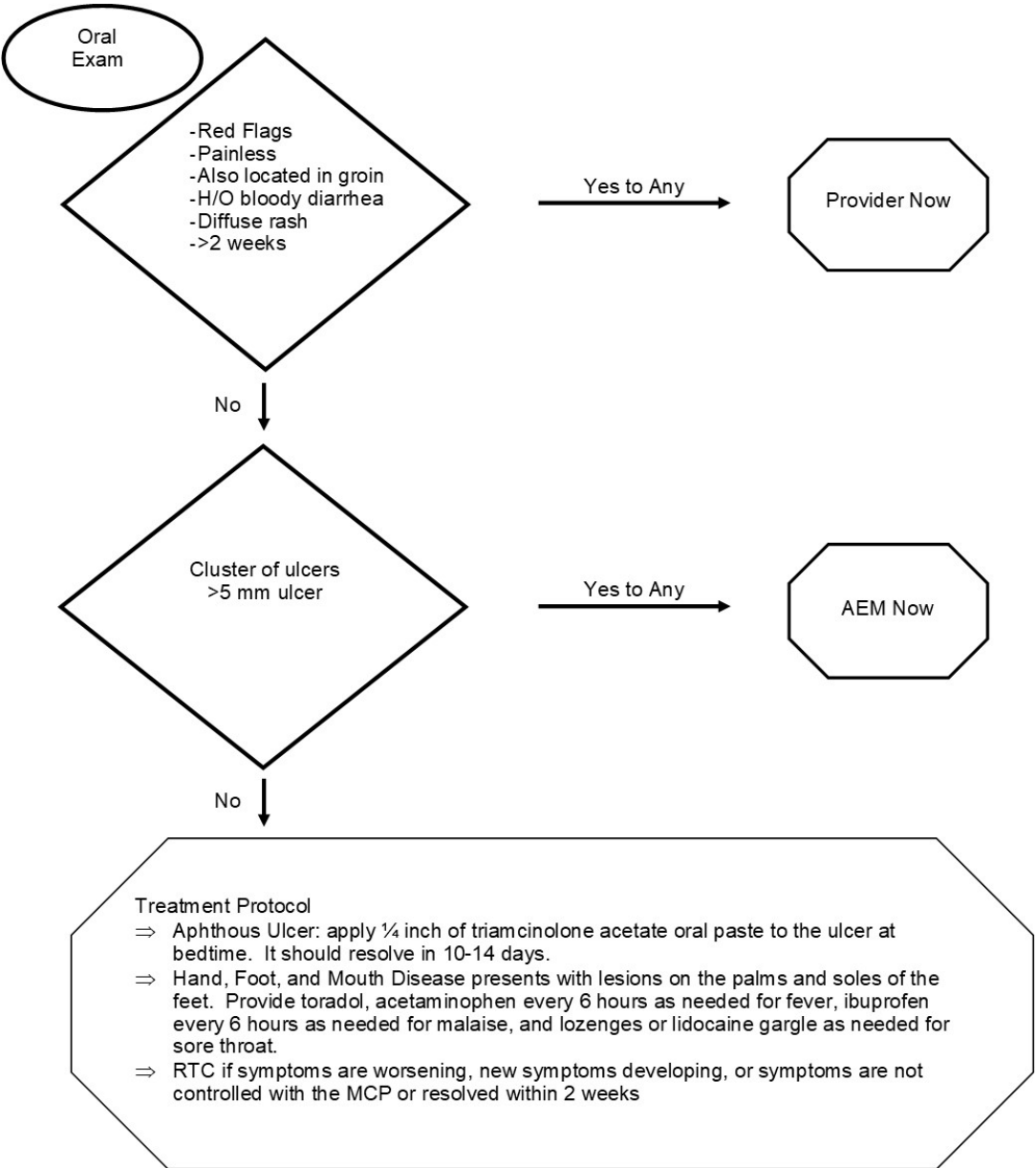
MCP for hand, foot, and mouth disease. Common in children. It presents with oval pale papules with a red rim on the palms and soles of the feet with an aphthous ulcer. Elevated temperature, feeling tired, and a sore throat often start before the lesions appear. Treatment is supportive. Provide acetaminophen as needed for elevated temperature and Ibuprofen as needed for malaise. Cepacol lozenges, salt water gargles (1/4 teaspoon of salt in 1 cup of warm water), and drinking warm fluids may also help with the sore throat.

Instruct the Soldier to return to the clinic for further evaluation if new symptoms develop, symptoms worsen, or the symptoms are not controlled with the current regimen or resolved within 2 weeks.

L-3: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training And Certifications	pg.68	(k)

SORES IN THE MOUTH, L-3

Partial Differential Diagnosis: Aphthous Ulcers Herpes Simplex Virus Hand, Foot, and Mouth Disease Stevens Johnson Syndrome	RED FLAGS - Diffuse - Bloody Diarrhea	Activity Modification: None
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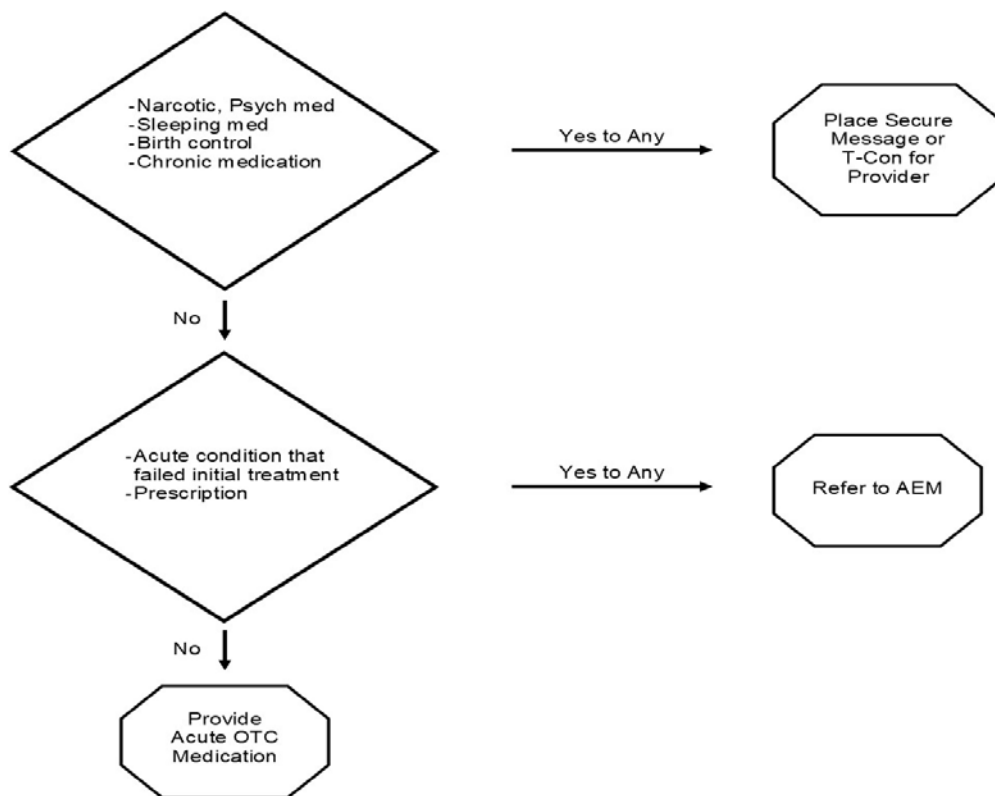
PRESCRIPTION REFILL, L-4

Use this protocol for all prescription refills except birth control pills. Birth control is screened under I-6, Request for Information on Contraception.

Some Soldiers request a refill of medication prescribed for an acute illness. Soldiers are normally given enough medication initially to cover the anticipated period of illness. If the Soldier wants additional medication, the illness may not be responding to the treatment as expected. In this case, the Soldier needs to be rescreened by his complaints. The only exception would be the Soldier who lost his original prescription.

DP 1: Narcotics, psychiatric medications, sleeping medicines, birth control, and chronic medications should be referred to a privileged provider as a secure message or telephone consult. The privileged provider will need to determine if the underlying condition is still being adequately treated and when the next follow-up appointment is needed.

DP 2: Acute conditions that have failed initial treatment should be referred to the AEM for further evaluation. Acute medication can be re-provided if the Soldier lost his or her medication. Prior to re-providing the medication, review the Soldier's medical record to determine how much longer he or she is supposed to be on the medication.



REQUESTS A VASECTOMY, L-5

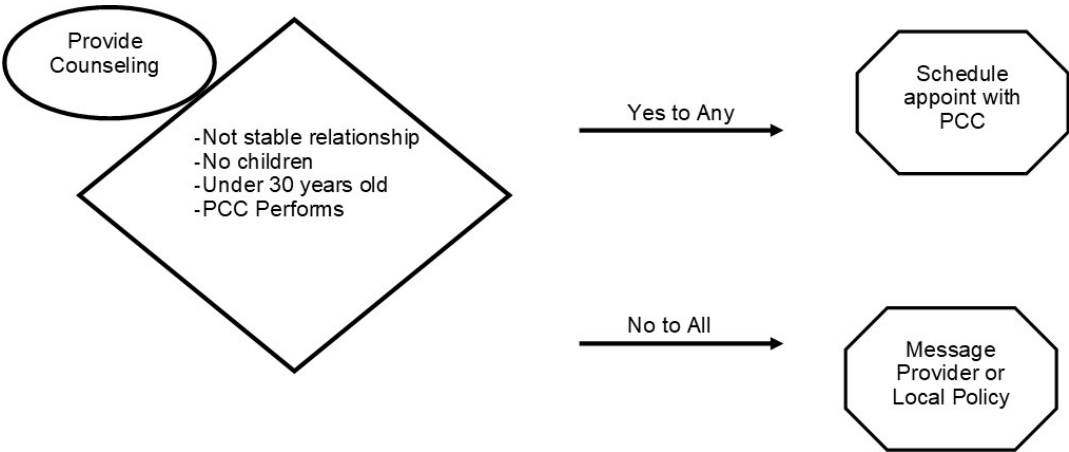
Counseling should be provided to the Soldier prior to scheduling an appointment with the PCM or placing a Secure Message or T-con for a referral. Counseling should include a discussion on contraception, brief overview of the procedure, and emphasis on the permanent nature of the procedure.

Vasectomy is an outpatient procedure. It is often performed in an office or procedure room with local anesthesia and a sedating medication to help the Soldier relax. The skin of the scrotum is cut or punctured, a section of the vas deferens is removed, and the vas deferens ends are closed. After the procedure, the Soldier rests for two to four days with support of the scrotum and application of an ice pack to the area. Soldier doesn't return to full duty for about 2 weeks.

A vasectomy is a permanent method of birth control. Reversal of the procedure is only about 50% effective and decreases with time. A vasectomy is not effective until after all of the sperm have been removed from the system. Lack of sperm needs to be confirmed by a lab test around three months. Alternate birth control will need to be used until the lack of sperm is confirmed. Pregnancy can still occur after vasectomy in 2% of people. Condoms are required to protect from STIs, if not in a committed monogamous relationship.

DP 1: Vasectomy is for permanent birth control. If the Soldier is not in a stable relationship with acceptance of the other person, doesn't already have kids, or is under 30 years old, then refer to the privileged provider for counseling prior to referring the Soldier for a vasectomy. If the privileged provider performs vasectomies, the privileged provider will need to counsel the Soldier before the procedure.

DP 2: Process to schedule a vasectomy varies by location. Message the privileged provider (secure messaging, T-con, etc.) to request a referral for the procedure or follow local process if different.

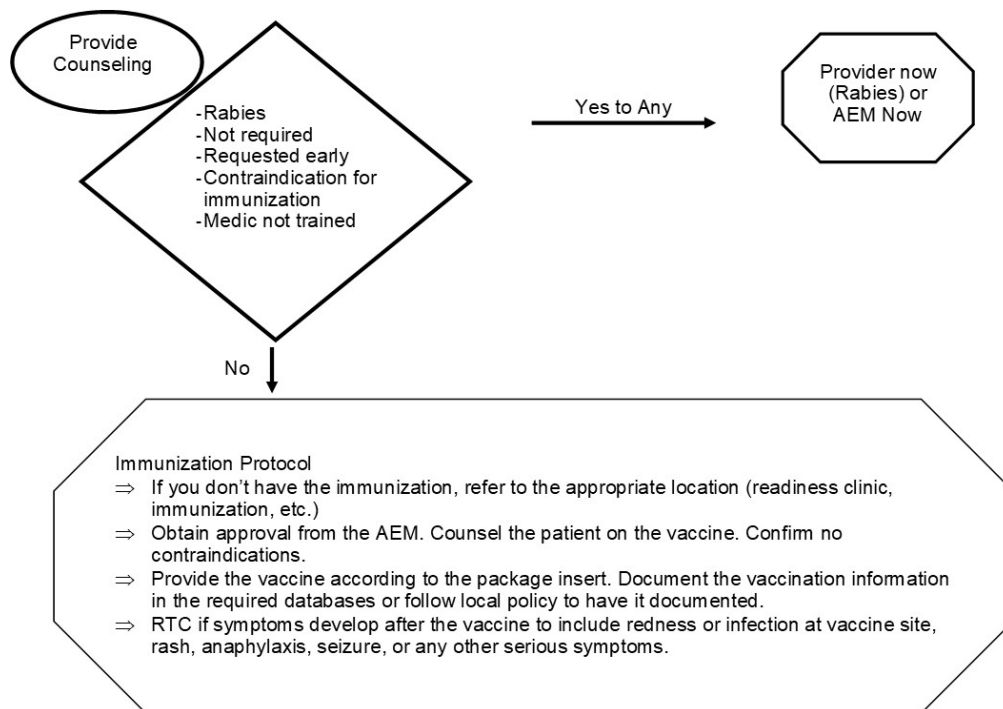


NEEDS AN IMMUNIZATION, L-6

DP 1: Rabies immunoglobulin needs to be referred to the supervising privileged provider. Routine immunizations are normally provided only at scheduled times. If the immunization is requested early, is not on the required immunization series, is contraindication, or you are not trained to provide, then refer the Soldier to the AEM. Contraindications include history of a severe reaction to a vaccine, eggs or egg protein, neomycin, or streptomycin. Being immunocompromised, around an immunocompromised person, or pregnant are contraindications that require further evaluation.

If the clinic does not have the immunization requested, refer the Soldier to the appropriate location (such as, readiness clinic, immunizations, etc.). If the clinic does have the immunization and you are trained to provide it, obtain approval from your AEM. After obtaining approval, counsel the Soldier on the immunization, confirm that there are no contraindications, and provide the vaccine according to the package insert. After providing the vaccine, document the vaccination information in the appropriate databases or follow the local policy to have the information documented. Have the Soldier return to clinic if symptoms develop after the vaccination to include a rash, local redness or infection, or fever.

L-6: In accordance with MEDCOM Regulation 40-50		
Per Provider Order, Administers And Records Appropriate Immunizations	pg.67	b.(1)



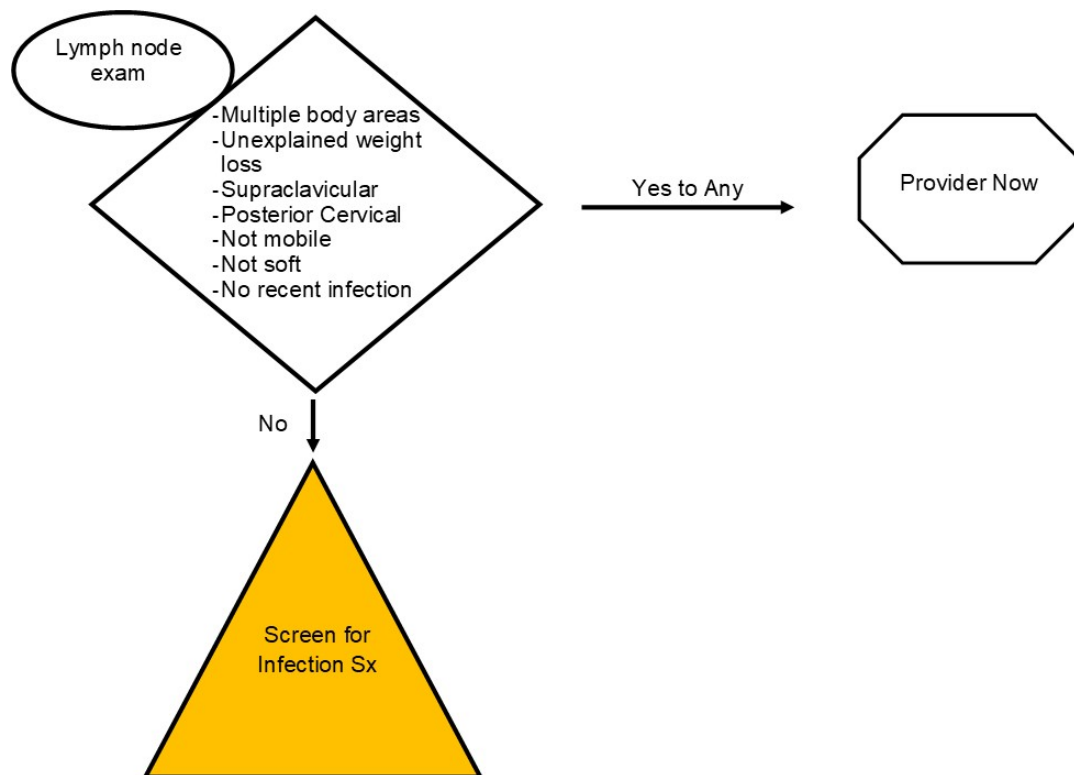
LYMPH NODE ENLARGEMENT, L-7

Enlarged lymph nodes are most commonly found in the neck, armpits, and groin and are locations where the body fights infection. A lymph node enlargement may result from an infection/inflammation in the area of the body drained by the node or from a systemic illness. In the former case, the enlarged nodes are likely to be confined to that area. In the latter case, lymph nodes in several areas of the body may be involved.

Red Flags. If the Soldier presents with any of the red flags, immediately disposition the Soldier as “Provider Now.” These can be signs of significant underlying medical problems.

DP 1: Unexplained weight loss and enlarged nodes in multiple body areas may represent a systemic illness. Supraclavicular and posterior cervical may represent a more concerning illness. Non-mobile and hard or rubbery nodes may represent nodal fibrosis. Lack a recent infection (within two weeks) or inflammation in the area of the lymph node to cause the lymph node to enlarge requires further evaluation by the supervising privileged provider.

DP 2: Lymph nodes that are associated with an infection or inflammation should be screened according to the infection or inflammation symptoms.



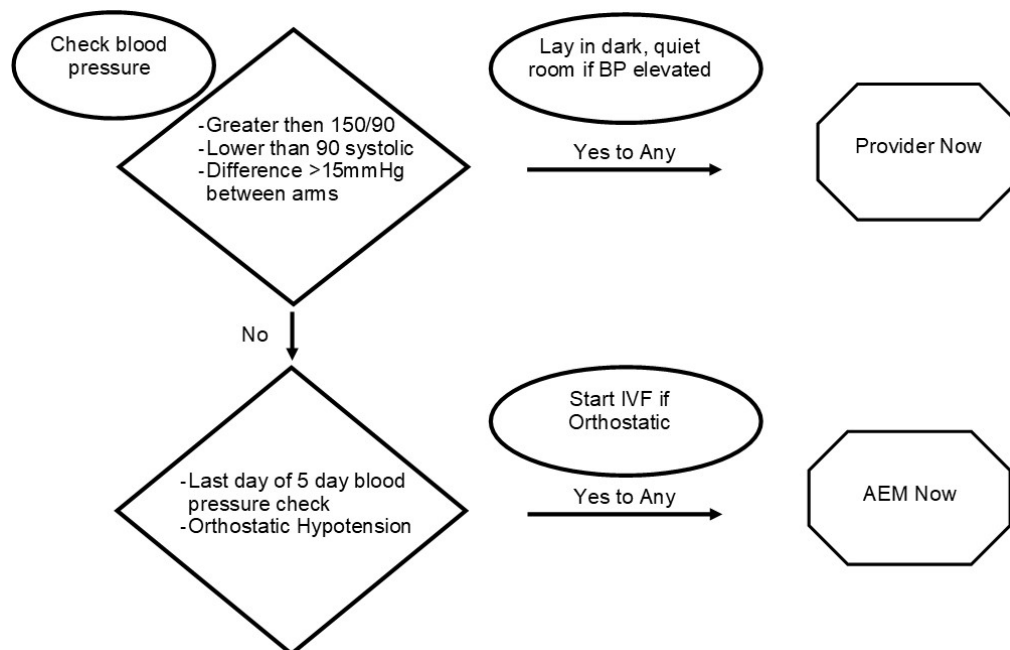
BLOOD PRESSURE CHECK, L-8

Systolic blood pressure is the top number which is the pressure in the blood vessels when the heart is pumping blood to the body. Diastolic blood pressure is the bottom number which is the pressure in the blood vessels when the heart is filling with blood between pumps. A normal blood pressure is 120/70. Blood pressure can result in medical problems when it is elevated over a long period of time. It can also result in acute problems when it is very low or very high.

DP 1: If the blood pressure is greater than 150/90, recheck the blood pressure after five minutes. If it is still greater than 150/90 or was lower than 90 systolic refer the Soldier to a privileged provider for evaluation. Blood pressure over 180/120 is considered severe (hypertensive urgency) and requires prompt treatment. Severe hypertension can cause permanent end organ damage. Have the Soldier lay down in a dark, quiet room while awaiting for transport or to be seen by the privileged provider. A difference of greater than 15mmHg between arms suggests an arterial issue.

DP 2: On the last day of the blood pressure check, refer the Soldier to the AEM to evaluate the recorded blood pressures. If it is not the last blood pressure check, remind the Soldier to return for his or her next check. Orthostatic hypotension is usually associated with feeling lightheaded upon standing and systolic blood pressure drops by 20, diastolic blood pressure drops by 10, or heart rate increases by 20 with standing.

L-8: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 1: Vital Signs	Measure a Patient's Blood Pressure	081-833-0012

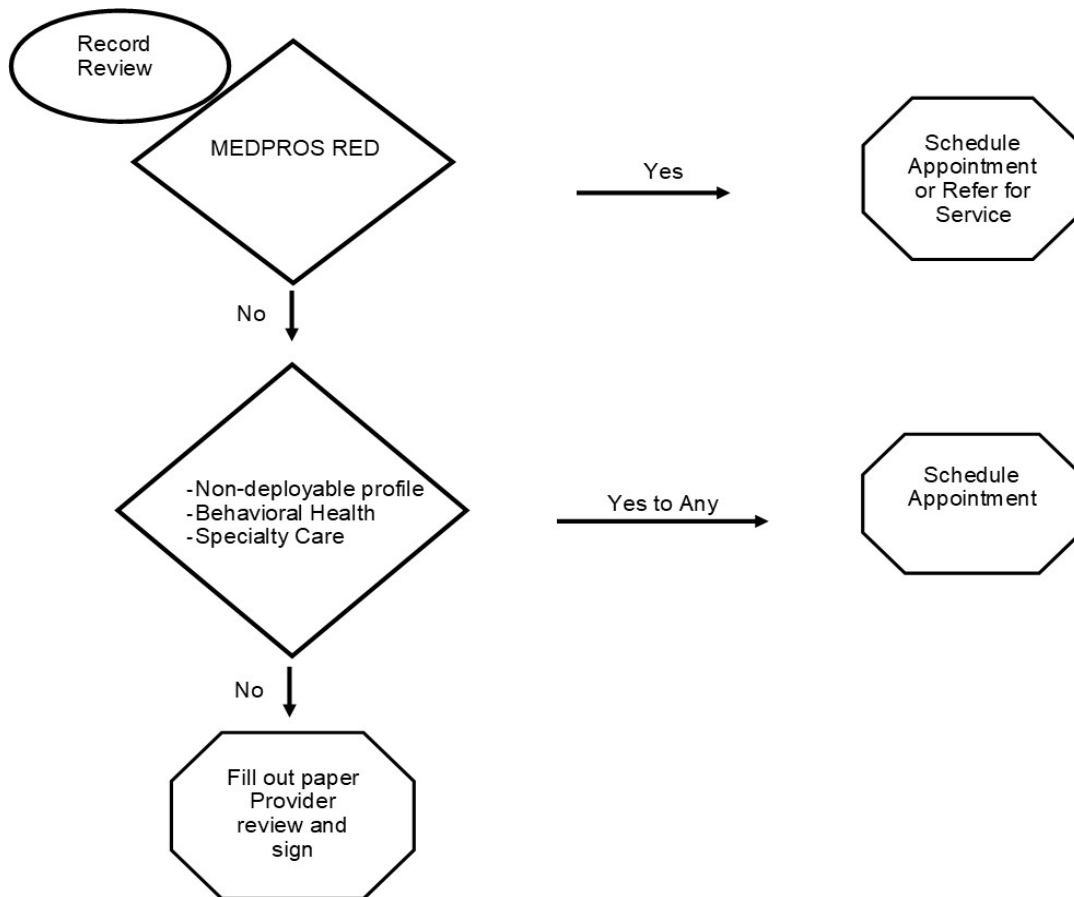


MEDICAL SCREENING FOR OVERSEAS PERMANENT CHANGE OF STATION, L-9

Soldiers on orders for overseas assignments require review of their medical records to determine if they have medical conditions that would preclude the assignment and to ensure their medical readiness is current. Record review should look for behavioral health appointments, specialty care appointments, e-profile (non-deployable profile), deployment health assessments due, pregnancy status, and MEDPROS data. MEDPROS includes hearing, dental, immunizations, HIV screen, vision screen, and PHA.

DP 1: If MEDPROS is identified as being red, instruct the Soldier on how to correct the medical readiness deficiencies, and schedule an appointment as needed.

DP 2: Identification of a non-deployable profile, behavioral health appointments, specialty care appointments, or a pregnant or postpartum Soldier requires a referral to the supervising privileged provider for further evaluation prior to having the form signed. If no deficiencies or issues are identified, fill out the form for the supervising privileged provider to review and sign. Instruct the Soldier to wait or return at a later specified time depending on supervising privileged provider availability and local policy.



WEIGHT REDUCTION, L-10

Individuals who come on sick call requesting assistance with weight control or diet therapy to reduce their weight should be seen by a dietitian if there are no medical problems that require evaluation.

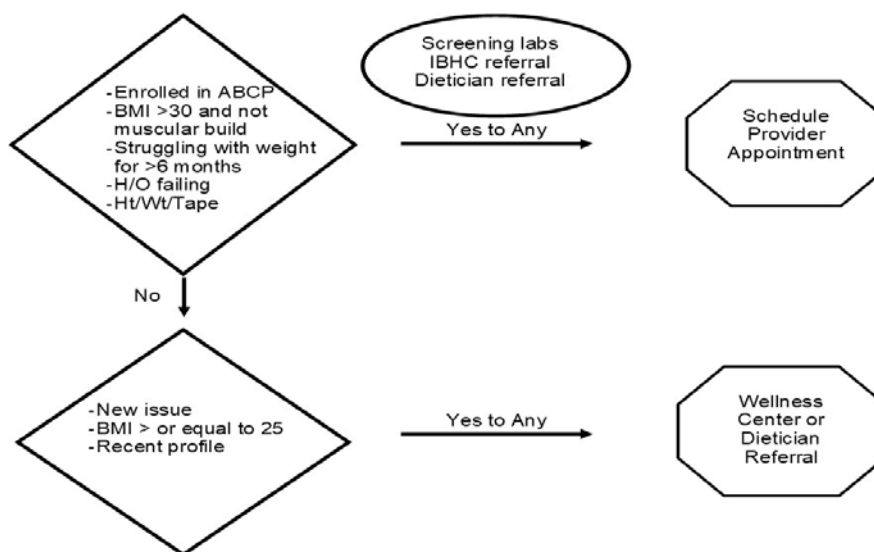
DP 1: Soldiers who are enrolled in the Army Body Composition Program (AR 600-9) are required to meet with a dietitian or privileged provider if a dietitian is not available. The privileged provider should screen the Soldier for medical causes of his or her weight gain.

Screening labs include TSH, lipids, fasting glucose, and liver function tests.

Hypothyroidism can cause weight gain and should be screened for with a TSH. Obesity is associated with diabetes, high cholesterol, and inflammation of the liver. Cholesterol, fasting glucose, and liver function tests should be screened to look for associated medical problems. Evaluation should also include screening for sleep apnea, hypertension, polycystic ovary syndrome, osteoarthritis, heartburn, and depression by history and physical exam. Soldier should be referred to the dietitian while the lab results and privileged provider appointment are pending. Integrated Behavioral Health consult should be offered and information about other poster services (wellness centered) provided. Same screening should be performed for Soldiers who's BMI is over 30, have been struggling to maintain their weight through multiple diets for over 6 months, or have a history of being placed on the Army Body Composition Program.

DP 2: Soldiers who are requesting assistance with weight control that is a new issue should be provided information on community resources that are available which may include the Wellness Center, access to a Dietician, an Athletic Trainer, or Strength and Conditioning Coach and offered a referral to Integrated Behavioral Health if available.

L-10: In accordance with MEDCOM Regulation 40-50		
Obtain Laboratory Specimen	pg.70	(k)



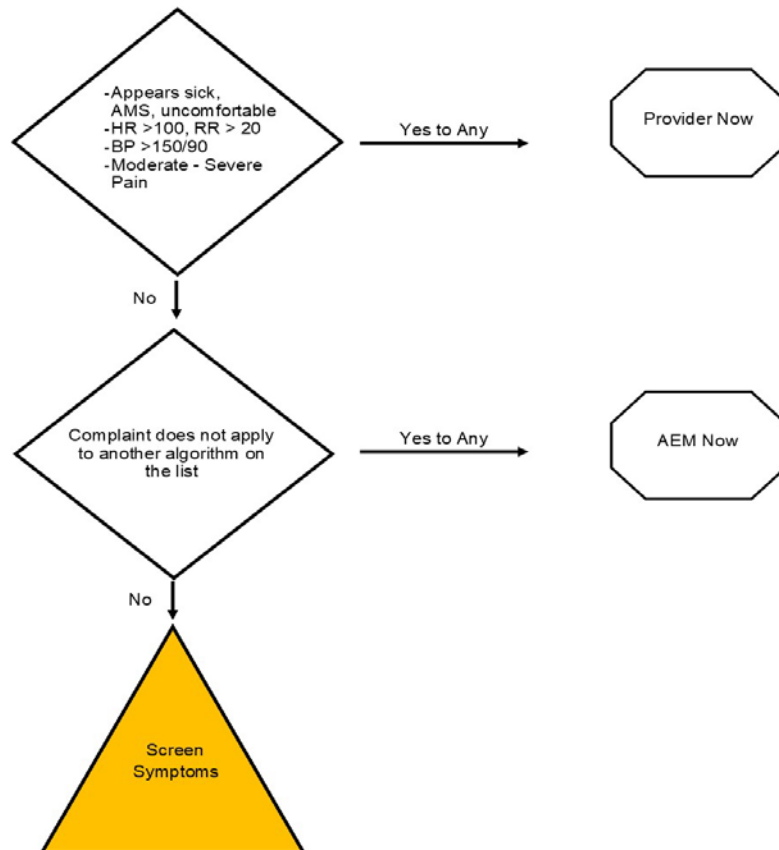
COMPLAINT NOT ON THE LIST, L-11

Any Soldier with a complaint not covered in this screening manual requires further evaluation.

DP 1: If Soldier appears sick or unstable (such as, pale, sweaty, dazed look in eyes), confused or has an altered mental status, uncomfortable (can't stop moving or refusing to move due to pain), has abnormal vital signs, or describes pain as five or higher, refer to the supervising privileged provider now for further evaluation and treatment. All of these scenarios may represent a more significant illness or injury.

DP 2: If the complaint is not on the list, does not fit under another protocol, and the Soldier appears stable with normal vital signs, refer to the AEM for further evaluation, treatment, and disposition. If the complaint is not on the list but you recognize it as being under a protocol on the list or another way of saying a complaint that is on the list, screen according to the protocol that the Soldier's complaint refers to.

L-11: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 1: Vital Signs	Measure a Patient's Blood Pressure	081-833-0012



REQUEST FOR NONPRESCRIPTION OR TRAVELING MEDICATIONS, L-12

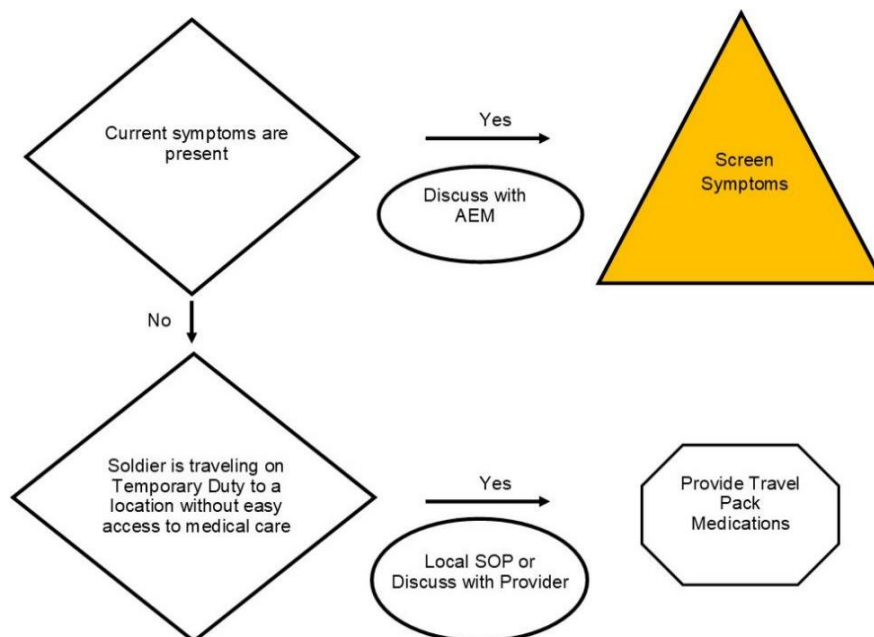
This protocol refers to Soldiers requesting specific nonprescription medications for minor-care.

DP 1: If the Soldier has symptoms, screen the Soldier according to the protocol that represents his or her symptoms. Since nonprescription medications can be dangerous if not used properly, the Soldier should be screened first to ensure that the medications requested are appropriate for his or her current symptoms.

DP 2: If a Soldier is traveling on temporary duty to a location where medical care is not easily accessible and local policy supports providing travel medications, he or she may request a travel pack of medications. Evaluate for the risk of malaria and other diseases. Discuss the request with the supervising privileged provider. Provide travel medications as authorized by your supervising privileged provider and local policy.

Example medications include ibuprofen (pain), diphenhydramine (allergies/ reaction), pseudoephedrine (congestion), loperamide and ciprofloxacin (diarrhea), doxycycline (malaria prophylaxis). **Supervising privileged provider must approve all travel medications.**

L-12: In accordance with MEDCOM Regulation 40-50		
All Medication Protocols Associated with 68W Training And Certifications	pg.68	(k)
L-12: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 1: Vital Signs	Measure a Patient's Blood Pressure	081-833-0012



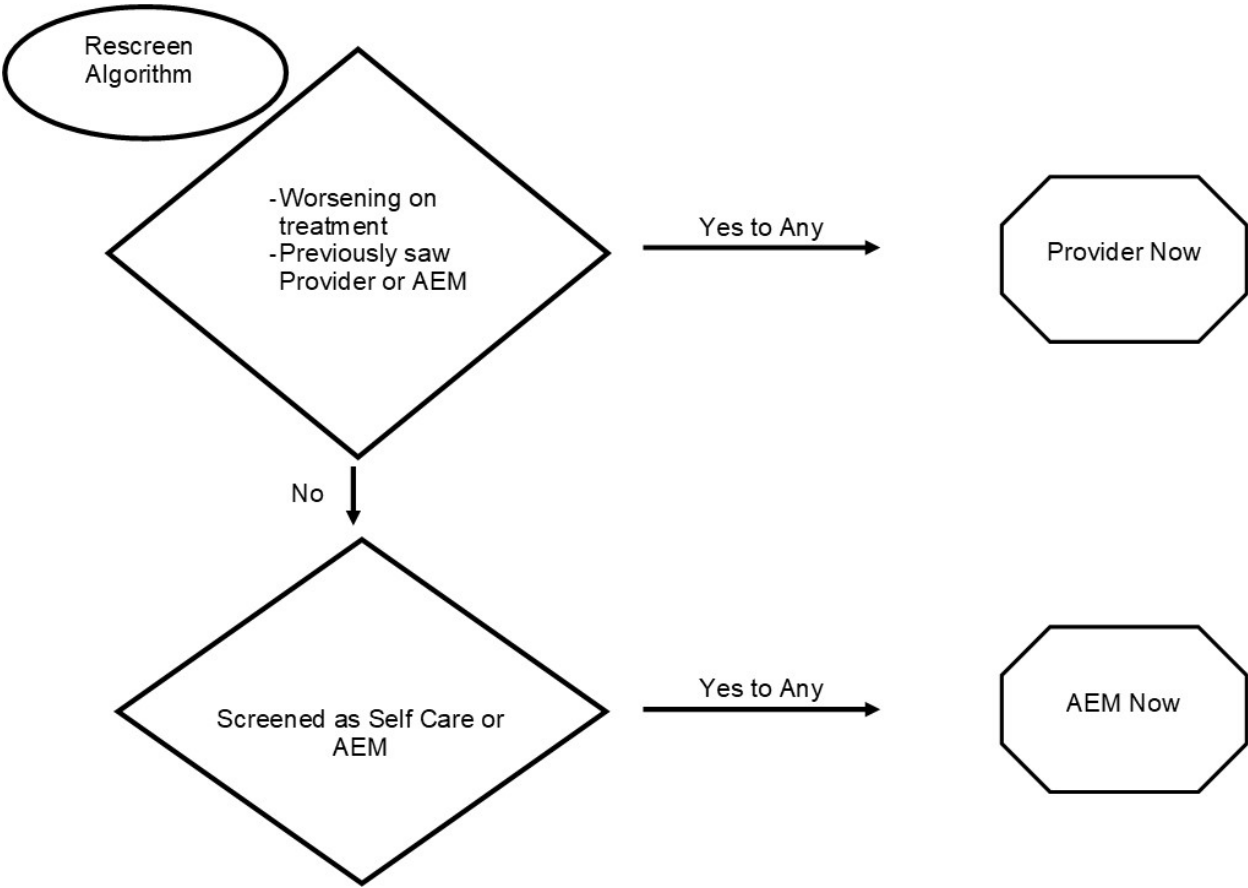
NO SIGNS OF IMPROVEMENT (NOT GETTING BETTER), M-1

This refers to a Soldier who returns for further care not part of a scheduled follow-up. **Soldier should NOT be screened to a minor-care protocol.** As a follow-up visit, the Soldier should receive a more detailed evaluation and be seen by the privileged provider or AEM (if treated with a minor care protocol at the previous visit).

DP 1: If the Soldier is worsening on treatment or failed the previous treatment regimen, he or she should be referred to the supervising privileged provider.

DP 2: **Soldier should not be screened to below the AEM level when he or she returns to the clinic for the same issue that was previously treated with minor-care. Soldier has the option to elevate his or her disposition to the next higher level (Provider Now) if he or she feels uncomfortable with seeing an AEM.**

M-1: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 1: Vital Signs	Measure a Patient's Blood Pressure	081-833-0012



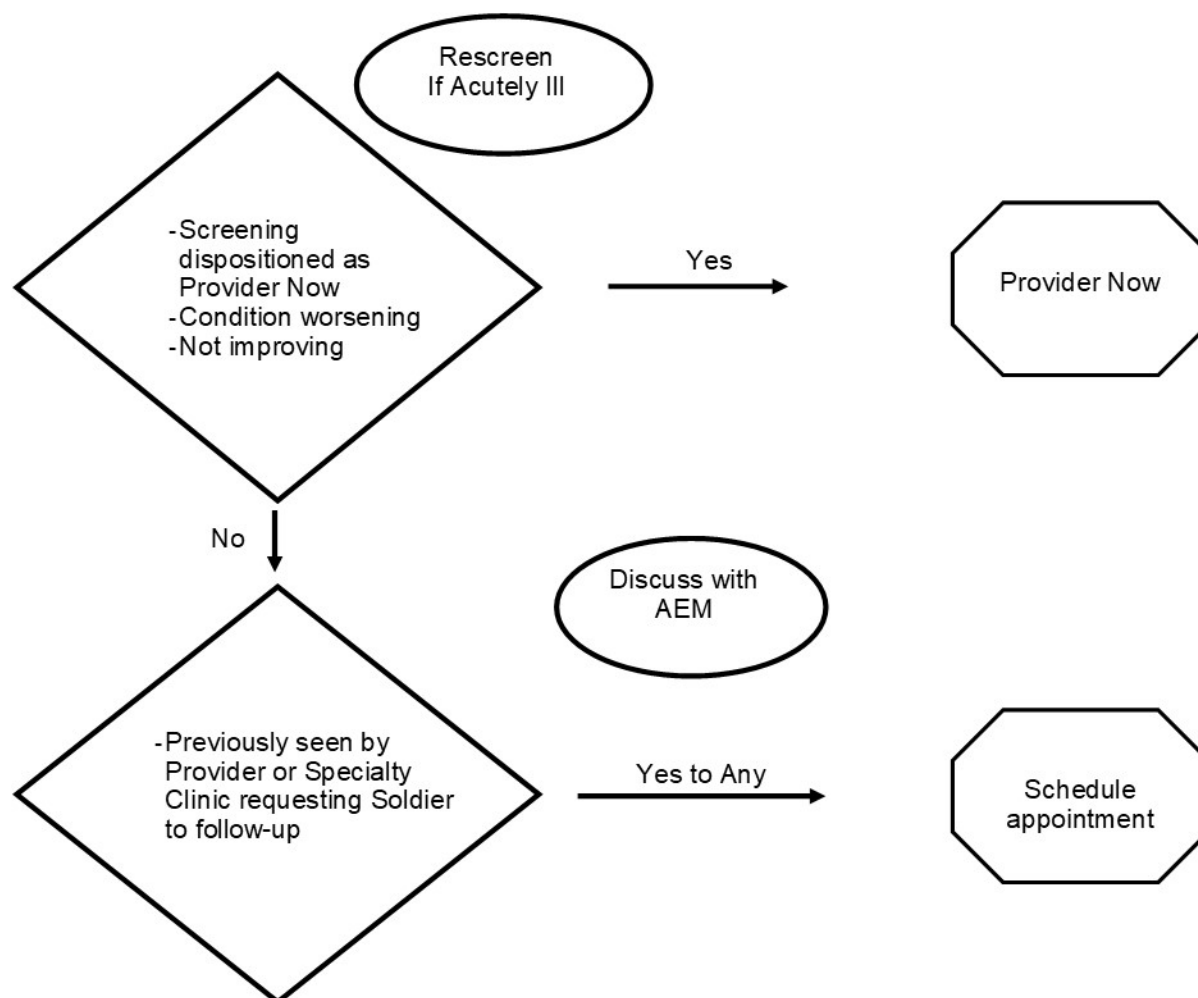
RETURN REQUESTED BY PROVIDER, M-2

Many Soldiers are told to return for follow up. Write the previous level of care and name of the privileged provider on the screening note.

DP 1: Rescreen the Soldier if he or she appears acutely ill. Refer to the supervising privileged provider if he or she is worsening, not improving, or screen as “Provider Now” in the protocol.

DP 2: If possible, refer the Soldier to the original privileged provider. If the original privileged provider is not available, discuss the situation with the AEM. Based on local policy and original privileged provider availability, the Soldier may be scheduled with a different privileged provider that is covering for the original privileged provider or scheduled with the original privileged provider when he or she is next available. Explain to the Soldier when his or her follow-up will be.

M-2: In accordance with STP 8-68W13-SM-TG Task		
Subject Area 1: Vital Signs	Measure a Patient’s Blood Pressure	081-833-0012



Appendix C List of medications

The following tables are a list of medications that are provided in the minor-care treatment protocols. Medications may be modified at the local level to include substitutions of the same class of medications with the same indications if approved by the Pharmacy & Therapeutics Committee and commander. Training and competency must be validated and documented in the location of record to include the competency assessment folder, Defense Training Management System, or similar system of record prior to medic being allowed to provide the medication. Soldier's allergies and LMP must be reviewed and the Soldier must be counseled on the indications, potential side effects, and proper way to take the medication (route, dosage, frequency) prior to dispensing the medication.

(Generic name highlighted in yellow): Indicates a medication requiring a privileged provider prescription to be dispensed.

(Brand name highlighted in green): Indicates a medication that is an Aeromedical Class 1 medication. If a flight surgeon is not immediately available, the Aeromedical Class 1 medication can be used on a short term basis until a flight surgeon can be seen for appropriate evaluation and treatment. Over-the-counter (OTC) medications frequently are combination medications, with one or more components contra-indicated for safety of flight. Combination medications are acceptable only when each component in the combination is separately acceptable. Any prohibited component makes the combination a prohibited medication.

ADTMC drug instructions will be highlighted in an orange to further separate out the ADTMC drug instructions from the rest of the drug reference.

ADTMC screener will notify the supervising privileged provider that the screening algorithm recommended a prescription or flight limiting (if Soldier is on flight status) medication, which medication, and the indications for the medication. Privileged provider will have the opportunity to request to have an appointment scheduled for them to evaluate the Soldier, see or talk with the Soldier, or discuss the Soldier's complaint with the medic or supervising NCO prior to the ADTMC screener entering the prescription. ADTMC screener will enter the prescription utilizing local SOPs, CSSPs, or protocols (to include ADTMC) upon approval by the supervising privileged provider. The supervising privileged provider will sign the order as soon as feasible to limit delays in the Soldier's care.

Anesthetic Medications

OTC Medication	Trade Name	Algorithm	Reference
Acetaminophen 325mg tab	Tylenol	B1-11, D1-2, E2, G2, I1, J14, L3	p. 181
Ibuprofen 200mg	Motrin, Advil	A1-3, B1-11, D1-2, E2, F2-4, I1,3, J14, K3, L3	P. 183
Naproxen 250mg	Aleve, Naprosyn	I3	p. 184

Prescription Medication	Trade Name	Algorithm	Reference
Menthyl Salicylate Menthol*	Ben Gay; Icy Hot	B11	p. 182
Lidocaine Gargle 2%*	Viscous Lidocaine	A1, L3	p. 185
Phenazopyridine 100mg*	Pyridium	E1,4	p. 186
Ketorolac 30mg*	Toradol	B1-11, E2, F2, I1,3, K3, L3	p. 187

Antibiotics, Antifungals, Antivirals, Antivector

OTC Medication	Trade Name	Algorithm	Reference
Bacitracin 500 units/ gram	Baciguent	J11-12,15	p. 188
Terbinafine 1%	Lamisil	J6-8	p. 189
Povidone Iodine	Betadine	J15, K7	p. 191
Benzoyl Peroxide 10%	Acne Treatment	J2	p. 192
Permethrin 1%	Nix	K6	p. 198

Prescription Medication	Trade Name	Algorithm	Reference
Azithromycin 1000mg*	Zithromax	E2-4	p. 190
Ceftriaxone 250mg*	Rocephin	E2-4	p. 193
Doxycycline 100mg*	Vibramycin, Adoxa	J2	p. 194
Fluconazole 150mg*	Diflucan	I4	p. 195
Metronidazole 250mg*	Flagyl	I4	p. 196
Nitrofurantoin 100mg*	Macrobid	E1,4	p. 197
Permethrin 5%*	Elimite	K6	p. 199
Trimethoprim (TMP) Sulfamethoxazole (SMX)	Bactrim, Septra	E1, E4	p. 200
Valacyclovir	Valtrex	E3, J10, L3	p. 201

Antihistamine

OTC Medication	Trade Name	Algorithm	Reference
Diphenhydramine 25mg	Benadryl	G1, J13	p. 202
Loratadine 10mg	Claritin	A3, D1-2	p. 203
Ranitidine 150mg	Zantac	C7, D2	p. 204

Cold Medications

OTC Medication	Trade Name	Algorithm	Reference
Benzocaine Lozenge	Cepacol	A1, L3	p. 205
Oxymetazoline (Decongestant)	Afrin	A2-3,5, D1-2	p. 206
Guaifenesin 100 mg/ 5 mL (Expectorant)	Mucinex, Robitussin, Tussin	A3, D1-2	p. 208

Prescription Medication	Trade Name	Algorithm	Reference
Pseudoephedrine 30mg* (Decongestant)	Sudafed	A2-3, D1-2	p. 207

Constipation/ Diarrhea Medications

OTC Medication	Trade Name	Algorithm	Reference
Polyethylene Glycol 17g (Bulking Agent)	Miralax	C4-5	p. 209
Docusate Sodium 100mg (Stool Softener)	Colace	C4-5	p. 210
Bisacodyl 5mg	Dulcolax	C5	p. 212
Bismuth Subsalicylate 262 mg/ 15 mL	Pepto-Bismol, Maalox	C2	p. 213

Prescription Medication	Trade Name	Algorithm	Reference
Loperamide 2mg*	Imodium	C2	p. 211

Emergency Medicines

Prescription Medication	Trade Name	Algorithm	Reference
Albuterol*	Proventil, Ventolin	D1-2	p. 214
Acetylsalicylic Acid (chewable) 81mg*	Aspirin, Bayer	C7, D1-2	p. 215
Epinephrine Auto Injector*	EpiPen	J13, K7	p. 216
Glucagon 1mg IV*	GlucaGen	C6	p. 217

Lotions and Topical Steroids

Calamine Lotion	Caladryl, Calayesic	J13, K7	p. 218
Aluminum Acetate	Domeboro Solution, Boro-Pack	J13	p. 219
Propylene glycol 0.6%	Systane Balance	H1	p. 220
Hydrocortisone 1% Cream	Westcort Cream	H2, J13,18, K7	p. 221

Prescription Medication	Trade Name	Algorithm	Reference
Acetic Acid and Hydrocortisone Ear Drops	Acetasol	A2	p. 222
Hydrocortisone 2.5% and Pramoxine 1% Cream	Analpram-HC	C4	p. 223
Adapalene 1%* Retinoid Cream	Differin	J2,3	p. 224

ACETAMINOPHEN**	TRADE NAME			
	Tylenol			
INDICATIONS	ADULT		PEDIATRIC	
	DOSE	ROUTE	DOSE	ROUTE
Pain or Fever	ADTMC Drug Instructions		NA	
	325 mg	PO	NA	NA
	Take 2 tabs every 6 hr daily as needed for fever or pain (Maximum: 2.6g in 24 hrs)		NA	
	Additional Drug Information		Additional Drug Information	
	325-650 mg	PO	15 mg/ kg/ dose	PO
	Every 4-6 hr or 1000 mg 3-4 times daily (Maximum: 4 g in 24 hrs)		Every 4-6 hr as needed (Maximum: 2.6 g in 24 hrs)	
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to acetaminophen or any component of the formulation <input type="checkbox"/> Hepatic impairment or liver disease				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
SAFE			CLASS B – PRESUMED SAFE	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Avoid use in patient suffering alcohol toxicity, known alcohol abuse , or renal impairment <input type="checkbox"/> Nausea, vomiting <input type="checkbox"/> G6PD deficiency				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Analgesic effect believed to be related to serotonergic inhibitory pathways in the CNS <input checked="" type="checkbox"/> Antipyresis from inhibition of the hypothalamic heat-regulating center				
AVIATION CONSIDERATIONS				
<input checked="" type="checkbox"/> Class 1 when used infrequently or in low dosage.				

MENTHYL SALICYLATE- MENTHOL (Analgesic Balm)*	TRADE NAME			
	BenGay, Icy Hot			
INDICATIONS	ADULT		PEDIATRIC	
	DOSE	ROUTE	DOSE	ROUTE
Pain Muscle Soreness	ADTMC Drug Instructions		Additional Drug Information	
	Balm	Topical	Balm, Cream	Topical
	Apply every 6-8 hours as needed for muscle soreness		>12 years old, use adult instructions	
	Additional Drug Information		Additional Drug Information	
	1.5% menthol	Patch	NA	NA
	Every 6-8 hrs as needed for pain (Do not leave in place for over 8 hrs)		NA	
	3% menthol	Patch	NA	NA
	Every 8-12 hours as needed for pain (Maximum: 2 uses/ day x 3 days)		NA	
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to aspirin, NSAIDS, menthol or any component of the formulation <input type="checkbox"/> Signs or symptoms of pain, swelling, blistering after application				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
UNKNOWN			Do Not use in last 3 months of pregnancy	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Do not apply to wounds, rashes, damaged skin, mucous membranes, or right after bathing <input type="checkbox"/> Do not use a heating pad after application <input type="checkbox"/> Can cause chemical burns at application site				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Analgesic and anti-inflammatory properties				

IBUPROFEN**	TRADE NAME		
	Motrin, Advil		
INDICATIONS	ADULT		
	DOSE	ROUTE	
Pain Osteoarthritis Rheumatoid Arthritis Antipyretic	ADTMC Drug Instructions		
	200 mg	PO	
	Take 2 tabs every 6 hours as needed for pain (Maximum: 1600 mg/ day)		
	Additional Drug Information		
	200- 800 mg	PO	
Additional Drug Information		PEDIATRIC (< 12 years)	
		DOSE	ROUT
		Additional Drug Information	
		NA	NA
		NA	
		Additional Drug Information	
		10 mg/ kg/ dose	PO
		Every 6 – 8 hrs as needed (Maximum single dose: 400 mg)	
CONTRAINDICATIONS			
<input type="checkbox"/> Hypersensitivity to ibuprofen or any component of the formulation <input type="checkbox"/> History of asthma, urticarial, or allergic-type reaction to aspirin or other NSAIDs <input type="checkbox"/> Aspirin triad (bronchial asthma, aspirin intolerance, rhinitis) <input type="checkbox"/> Use in the setting of coronary artery bypass graft (CABG) surgery or gastrointestinal bleeding			
SAFETY IN LACTATION		SAFETY IN PREGNANCY	
Enters Milk-Preferred		CLASS C – Avoid 1 st , 3 rd Trimester	
ADVERSE REACTIONS/PRECAUTIONS			
<input type="checkbox"/> Dizziness, headache, and tinnitus <input type="checkbox"/> Skin rash, itching <input type="checkbox"/> Epigastric pain, heartburn, and nausea			
MECHANISM OF ACTION			
<input checked="" type="checkbox"/> Reversibly inhibits cyclooxygenase-1 and 2 (COX-1 and 2) enzymes, which results in decreased formation of prostaglandin precursors <input checked="" type="checkbox"/> Has antipyretic, analgesic, and anti-inflammatory properties			

NAPROXEN**	TRADE NAME			
	Aleve, Naprosyn			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
	ADTMC Drug Instructions		Additional Drug Information	
Pain	250 mg	PO	NA	NA
Osteoarthritis	Take 1 tab every 12 hrs as needed for pain (Maximum: 500 mg/ day)		NA	
Gout	Additional Drug Information		Additional Drug Information	
Primary Dysmenorrhea	250-500 mg	PO		PO
	Every 12 hours as needed (Maximum: 1000 mg/ day)		Every 12 hours as needed (Maximum: 10 mg/ kg/ day)	
CONTRAINDICATIONS				
<ul style="list-style-type: none"> <input type="checkbox"/> Hypersensitivity to naproxen or any component of the formulation <input type="checkbox"/> History of asthma, uricarial, or allergic-type reaction to aspirin or other NSAIDs <input type="checkbox"/> Aspirin triad (bronchial asthma, aspirin intolerance, rhinitis) <input type="checkbox"/> Use in the setting of coronary artery bypass graft (CABG) surgery, kidney disease, or gastrointestinal bleeding 				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Enters Milk- Not Preferred			Avoid 1 st , 3 rd Trimester	
ADVERSE REACTIONS / PRECAUTIONS				
<ul style="list-style-type: none"> <input type="checkbox"/> Dizziness, drowsiness, headache, and tinnitus <input type="checkbox"/> Skin rash, itching <input type="checkbox"/> Epigastric pain, heartburn, nausea, constipation 				
MECHANISM OF ACTION				
<ul style="list-style-type: none"> ✓ Reversibly inhibits cyclooxygenase-1 and 2 (COX-1 and 2) enzymes, which results in decreased formation of prostaglandin precursors ✓ Has antipyretic, analgesic, and anti-inflammatory properties 				

LIDOCAINE GARGLE*	TRADE NAME			
	Viscous Lidocaine 2%			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
	ADTMC Drug Instructions		Additional Drug Information <3 years of age	
Severe	15 mL	PO	<1.2 mL	PO
Sore Throat	Swish and spit every 6 hours as needed for pain (Maximum: 4 doses/ 24 hrs)		Every 3 hours with cotton applicator Maximum: 4 doses/ 12 hours	
Mouth Sores	Additional Drug Information		Additional Drug Information 3 years of age or older	
	15 mL	PO	4.5 mg/ kg	PO
	Every 3 hours swish and spit as needed (Maximum: 8 doses/ 24 hours)		Every 3 hours swish and spit as needed Do not swallow Maximum: 300mg/ dose, 4 doses/ 12 hours	
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to lidocaine to any component of the formulation. <input type="checkbox"/> Do not use for teething in children. Seizures and death reported in children when not administered by strict adherence to dosing recommendations.				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Enters Milk- Safe			Class B- Limited Risk	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Severely traumatized mucosa increases the risk of rapid systemic absorption <input type="checkbox"/> May impair swallowing and increase aspiration risk. Avoid food for 60min after use <input type="checkbox"/> Tongue/ buccal biting after use				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Blocks the conduction of nerve impulses by decreasing the neuronal membrane's permeability to sodium ions, resulting in inhibition of depolarization and blockage of conduction.				

PHENAZOPYRIDINE* **	TRADE NAME			
	Pyridium			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
Dysuria	ADTMC Drug Instructions		Additional Drug Information	
	100 mg	PO	NA	NA
	Take 2 tabs every 8 hours after meals as needed for pain with urination Use with an antibiotic (Maximum: 600 mg per day for 2 days)		NA	
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to phenazopyridine or any component of the formulation <input type="checkbox"/> Discontinue if skin or sclera develop a yellow color <input type="checkbox"/> Kidney Disease/ Renal Impairment <input type="checkbox"/> G6PD deficiency				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
UNKNOWN			CLASS B – PRESUMED SAFE	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Headache, Dizziness <input type="checkbox"/> Stomach Cramps <input type="checkbox"/> Discolor urine, fabric or clothing, contacts (if touching after touching tablets)				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> An azo dye that is excreted in the urine and has analgesic effect on urinary tract mucosa <input checked="" type="checkbox"/> Unknown mechanism				

KETOROLAC*	TRADE NAME			
	Toradol			
INDICATIONS	ADULT		PEDIATRIC	
	DOSE	ROUTE	DOSE	ROUTE
Moderate Pain	ADTMC Drug Instructions		Additional Drug Information	
	30 mg	IM	NA	NA
	Inject one dose at presentation if needed for moderate pain		NA	
	Additional Drug Information		Additional Drug Information	
	30 mg	IM, IV	NA	NA
	30-60 mg IM or 30 mg IV every 6 hrs as needed Maximum: 120 mg day, 5 days total		NA	
CONTRAINDICATIONS				
<ul style="list-style-type: none"> <input type="checkbox"/> Hypersensitivity to ketorolac, aspirin, other NSAIDs or any component of the formulation <input type="checkbox"/> History of CABG, cardiovascular disease, gastrointestinal bleeding, cerebrovascular bleeding, or bleeding risk <input type="checkbox"/> History of asthma, urticarial, or allergic-type reaction to aspirin or other NSAIDs <input type="checkbox"/> Aspirin triad (bronchial asthma, aspirin intolerance, rhinitis) <input type="checkbox"/> Renal disease or volume depletion, receiving other NSAIDs or aspirin <input type="checkbox"/> During labor and delivery 				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Enters Milk- Not preferred			CLASS C – Unsafe	
ADVERSE REACTIONS/PRECAUTIONS				
<ul style="list-style-type: none"> <input type="checkbox"/> Headache <input type="checkbox"/> Gastrointestinal pain, heartburn, nausea <input type="checkbox"/> Drowsiness, dizziness, blurred vision 				
MECHANISM OF ACTION				
<ul style="list-style-type: none"> ✓ Inhibits cyclooxygenase-1 and 2 (COX-1 and 2) enzymes ✓ Has antipyretic, analgesic, and anti-inflammatory properties. 				

BACITRACIN** (Antibacterial Ointment)	TRADE NAME	
	Baciguent	
INDICATIONS	ADULT	
	DOSE	ROUTE
Skin Infection Cut, Abrasion Blister Burn	ADTMC Drug Instructions	
	500 units/ g	Topical
	Apply ointment 2-3 times per day to protect skin and help it heal	
	Additional Drug Information	
	500 units/ g	Topical
	Apply 1-3 times per day	
PEDIATRIC (< 12 years)		
DOSE	ROUTE	
Additional Drug Information		
NA	NA	
NA		
Additional Drug Information		
500 units/ g	Topical	
500 units/ g	Topical	
Apply 1-3 times per day		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to bacitracin or any component of the formulation		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Considered Safe	Considered Safe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Limit use to 1 week. If condition remains after 1 week, Soldier should be seen by a provider.		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Inhibits bacterial cell wall synthesis by preventing the transfer of mucopeptides into the growing bacterial cell wall <input checked="" type="checkbox"/> Maintains a moist environment allowing for skin growth and repair		

TERBINAFINE** (Antifungal Cream)	TRADE NAME	
	Lamisil	
INDICATIONS	ADULT	
	DOSE	ROUTE
Athlete's Foot (Tinea pedis) Jock Itch (Tinea cruris) Body Fungal Infection (Tinea corporis)	ADTMC Drug Instructions	
	Cream 1%	Topical
	Apply to affected area x 1 week Twice a day (Tinea pedis) Daily (Tinea cruris, corporis)	
	Additional Drug Information	
	Cream 1%	Topical
	Apply to affected area x 1 week Daily (Tinea cruris, corporis) Twice a day (Tinea pedis)	
	Twice a day x 2 weeks (sides and soles of feet)	
CONTRAINDICATIONS		
<input type="checkbox"/> Local irritation develops <input type="checkbox"/> If dosage form contains benzyl alcohol, can cause a fatal toxicity in neonates.		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Do Not apply near the breast	Safe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Contact dermatitis, burning sensation, irritation <input type="checkbox"/> Not intended for use on nails, scalp, or mucosa		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Synthetic allylamine derivative inhibits squalene epoxidase, a key enzyme in the sterol biosynthesis in fungi. <input checked="" type="checkbox"/> Results in fungal cell death.		

AZITHROMYCIN* **	TRADE NAME	
	Zithromax	
INDICATIONS	ADULT	
	DOSE	ROUTE
Cervicitis empiric therapy Urethritis empiric therapy Chlamydia trachomatis Gonococcal infection	ADTMC Drug Instructions	
	1 g	Oral
	Give one dose and observe while it is being taken (Give with Ceftriaxone)	
	Additional Drug Information	
	1gm	Oral
Single oral dose that is observed being taken (Given with Ceftriaxone)		
PEDIATRIC (< 12 years)		
DOSE	ROUTE	
Additional Drug Information		
NA	NA	
NA		
Additional Drug Information		
1gm	Oral	
If > 45.5kg 1 gm as single dose		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to azithromycin, erythromycin, other macrolide antibiotics or any component of the formulation <input type="checkbox"/> QT interval prolongation or history of arrhythmias <input type="checkbox"/> Liver Disease or Severe Renal Impairment		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Use Caution; Enters Milk	Class B- Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Diarrhea, nausea/ vomiting, GI upset		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Macrolide Antibiotic <input checked="" type="checkbox"/> Inhibits RNA-dependent protein synthesis in susceptible organisms		

<i>POVIDONE IODINE**</i>	TRADE NAME			
	Betadine			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
Antiseptic	ADTMC Drug Instructions		Additional Drug Information	
	Dose	Topical	NA	NA
	Apply to affected area as needed to clean the skin		NA	
	Additional Drug Information		Additional Drug Information	
		Topical	NA	NA
	Apply to affected areas as needed for antiseptic		NA	
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to iodine, shellfish, or any component of the formulation <input type="checkbox"/> Use with caution in patients with renal impairment or thyroid disorders <input type="checkbox"/> Do not use with deep puncture wounds or serious burns				
SAFETY IN LACTATION		SAFETY IN PREGNANCY		
Use Caution; Enters Milk		CLASS B– Presumed Safe		
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Irritation, itching, rash				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Broad spectrum germicidal agent effective against bacteria, viruses, fungi, protozoa, and spores				

CEFTRIAXONE* **	TRADE NAME			
	Rocephin			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
	ADTMC Drug Instructions		Additional Drug Information	
	250 mg	IM	50 mg/ kg	IM/ IV
	Inject into a large muscle mass (gluteus) one time (Dilute with sterile water or 1% lidocaine)		Disseminated Infection, <45kg Daily for 7 days (Max dose: 1,000 mg)	
Additional Drug Information		Additional Drug Information		
250-500 mg	IM	1,000 mg	IM/ IV	
One time injection -250 mg for initial therapy -500 mg if failed initial therapy		Disseminated, >45kg 1,000 mg daily for 7 days		
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to ceftriaxone, penicillin, or beta-lactam antibiotics <input type="checkbox"/> Do NOT use with neonates due to risk of hyperbilirubinemia <input type="checkbox"/> Do NOT use with calcium-containing solutions due to causing calcium-ceftriaxone precipitates				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Use Caution; Enters Milk			CLASS B– Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Induration or warm sensation at injection site <input type="checkbox"/> Rash or Diarrhea <input type="checkbox"/> Pancreatitis, Hemolytic anemia, Elevated INR				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> 3 rd Generation Cephalosporin <input checked="" type="checkbox"/> Inhibits bacterial cell wall synthesis <input checked="" type="checkbox"/> Bacteria eventually lyse due to cell wall autolytic enzyme activity without concomitant synthesis activity				

DOXYCYCLINE* **	TRADE NAME	
	Adoxa, Vibramycin	
INDICATIONS	ADULT	
	DOSE	ROUTE
Acne Malaria chemoprophylaxis Cellulitis	ADTMC Drug Instructions	
	100 mg	Oral
	Acne: 100 mg daily (used with topical agents) Malaria chemoprophylaxis: 100 mg daily, start 2 days before leaving	
	Additional Drug Information	
	100 mg	Oral
	Bite: 100 mg Every 12 hrs x 3-5 days Cellulitis: 100 mg Every 12 hrs x 7-14 days Lyme: 100 mg Every 12 hrs x 10-28 days	
PEDIATRIC (< 12 years)		
	DOSE	ROUTE
	Additional Drug Information	
	2-4 mg/ kg/ day	Oral
	>8 yrs old, <45kg 2-4 mg/ kg/ day in 1-2 divided doses (maximum: 200 mg/ day)	
	Additional Drug Information	
	100 mg	Oral
	>8 yrs old, >45kg Refer to Adult Dosing	
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to doxycycline, other tetracyclines, or any component of the formulation		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Use Caution; Enters Milk	CLASS D– Unsafe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Take medication with food or 8oz water and sit-up for 30minutes after taking (prevent esophagitis) <input type="checkbox"/> Photosensitivity with increased risk of sunburn <input type="checkbox"/> Diarrhea, Severe skin reactions, Liver toxicity, Intracranial hypertension (blurry vision, headache, double vision)		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Tetracycline Antibiotic <input checked="" type="checkbox"/> Inhibits protein synthesis of ribosomal subunits of susceptible bacteria		

FLUCONAZOLE*	TRADE NAME	
	Diflucan	
INDICATIONS	ADULT	
	DOSE	ROUTE
Vaginal Yeast Infection	ADTMC Drug Instructions	
	150 mg	Oral
	Take 1 tab by mouth one time	
	Additional Drug Information	
	150 mg	Oral
	Severe: 150 mg every 72 hrs for 2-3 doses Recurrent: 150 mg daily x 10-14 days, then 150 mg weekly x 6 months	
PEDIATRIC (< 12 years)		
DOSE		ROUTE
Additional Drug Information		
NA		NA
NA		
Additional Drug Information		
NA		NA
NA		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to fluconazole or any component of the formulation <input type="checkbox"/> QTc Prolongation, Heart Arrhythmia		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Safe; Enters Milk		Unsafe
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Dizziness or Seizures <input type="checkbox"/> Hepatotoxicity		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Antifungal <input checked="" type="checkbox"/> Interferes with fungal cytochrome P450 activity inhibiting cell membrane formation		

METRONIDAZOLE*	TRADE NAME	
	Flagyl	
INDICATIONS	ADULT	
	DOSE	ROUTE
	ADTMC Drug Instructions	
	250 mg Oral Take 2 tabs twice a day for 7 days	
Bacterial Vaginosis	Additional Drug Information	
	250-1000 mg Oral	
	Different conditions: 250-1000 mg 2-4 times/ day	
PEDIATRIC (< 12 years)		
DOSE	ROUTE	
Additional Drug Information		
NA NA NA		
Additional Drug Information		
30-50mg/kg Oral Divided over 3 doses (Maximum: 2,250 mg/ day)		
CONTRAINDICATIONS		
<input type="checkbox"/> Do Not use alcohol when taking or within 3 days of taking. Can cause disulfiram-like reaction (flushing, tachycardia, nausea, vomiting) <input type="checkbox"/> Do not take during 1 st Trimester of pregnancy. <input type="checkbox"/> History of seizures		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Unsafe- Stop nursing for 3 days after		CLASS B– Not in 1 st Trimester
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> GI: nausea, vomiting, diarrhea, constipation, stomach cramps, anorexia <input type="checkbox"/> Neuropathic: neuropathy, confusion, dizziness, metallic taste, headache		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Cytotoxic to anaerobic bacteria <input checked="" type="checkbox"/> Disrupts DNA structure resulting in DNA strand breakage and inhibition of protein synthesis with resulting cell death in susceptible organisms		

NITROFURANTOIN MONOHYDRATE* **	TRADE NAME	
	Macrobid	
INDICATIONS	ADULT	
	DOSE	ROUTE
Urinary Tract Infection	ADTMC Drug Instructions	
	100 mg	Oral
	Take 1 capsule twice a day for 5 days	
	Additional Drug Information	
	50-100 mg	Oral
Nitrofurantoin monohydrate: 100 mg every 12 hrs x 5 days Nitrofurantoin macrocrystals: 50-100 mg every 6hrs x 7 days UTI prophylaxis: 50-100 mg daily at Bedtime		
PEDIATRIC (< 12 years)		
DOSE		ROUTE
Additional Drug Information		
NA		NA
NA		NA
Additional Drug Information		
5-7 mg/ kg/ day		Oral
Nitrofurantoin macrocrystals: Divide in 4 doses (every 6 hrs) x 7 days (max: 400 mg /day)		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to Nitrofurantoin or any component of the formulation <input type="checkbox"/> Pregnancy close to term/ delivery and neonates due to risk of hemolytic anemia <input type="checkbox"/> Renal impairment (anuria, oliguria), history of cholestatic jaundice or hepatic dysfunction from previous use		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Safe with Monitoring		CLASS B– Not at Term
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Liver failure, Peripheral neuropathy, Pulmonary toxicity		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Antibiotic <input checked="" type="checkbox"/> Alter bacterial ribosomal proteins inhibiting protein synthesis, aerobic energy metabolism, and cell wall synthesis		

PERMETHRIN 1%**	TRADE NAME	
	Nix	
INDICATIONS	ADULT	
	DOSE	ROUTE
Head Lice Pubic Lice	ADTMC Drug Instructions	
	1%	Topical
	Head Lice- 1%, leave on 10 min then rinse. Remove nits with comb. Repeat in 7 days.	
	Pubic Lice- 1%, leave on 10 min then rinse.	
	Additional Drug Information	
	1%	Topical
Head Lice-may repeat in 7 days		
PEDIATRIC (< 12 years)		
DOSE	ROUTE	
Additional Drug Information		
1%	Topical	
Head Lice- 1%, >2 months old, adult dosing		
Additional Drug Information		
NA	NA	
NA		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to any pyrethrin or pyrethroid, or any component of the formulation <input type="checkbox"/> Do Not come in contact with mucosal surfaces (eyes, inside nose, mouth, ear, or vagina) <input type="checkbox"/> Ragweed allergy- consult provider because can cause difficulty breathing		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown	CLASS B– Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Skin irritation <input type="checkbox"/> Localized numbness, tingling		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Antiparasitic Agent <input checked="" type="checkbox"/> Inhibits sodium membrane channels in parasites resulting in paralysis and death		

PERMETHRIN 5%* **	TRADE NAME	
	Elimite	
INDICATIONS	ADULT	
	DOSE	ROUTE
Scabies	ADTMC Drug Instructions	
	5%	Topical
	Scabies- 5%, apply 30 g from head to soles, leave on 8-14 hrs then rinse.	
	Additional Drug Information	
	5%	Topical
	Scabies- may repeat in 14 days	
PEDIATRIC (< 12 years)		
DOSE	ROUTE	
Additional Drug Information		
5%	Topical	
Scabies- 5%, >2 months old, adult dosing		
Additional Drug Information		
NA	NA	
NA		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to any pyrethrin or pyrethroid, or any component of the formulation <input type="checkbox"/> Do Not come in contact with mucosal surfaces (eyes, inside nose, mouth, ear, or vagina) <input type="checkbox"/> Ragweed allergy- consult provider because can cause difficulty breathing		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown	CLASS B– Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Skin irritation <input type="checkbox"/> Localized numbness, tingling		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Antiparasitic Agent <input checked="" type="checkbox"/> Inhibits sodium membrane channels in parasites resulting in paralysis and death		

TRIMETHOPRIM (TMP),* ** SULFAMETHOXAZOLE (SMX)	TRADE NAME			
	Septra, Bactrim			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
Urinary Tract Infection REVIEW LOCAL ANTIBIOGRAM FOR POTENTIAL RESISTANCE	ADTMC Drug Instructions		Additional Drug Information	
	160 mg/ 800 mg	Oral	NA	NA
	Take 1 doubles strength (DS) tab (160 mg/ 800 mg) twice a day for 3 days		NA	
	Additional Drug Information		Additional Drug Information 6-12mg TMP/ kg/ day	
	160 mg/ 800 mg	Oral	6-12 mg TMP/ kg/ day	Oral/ IV
1-2 DS tabs 1-2 times/ day Dosing based on TMP		Divided over 2 doses (Every 12 hrs) (Maximum: 160mg TMP/ dose)		
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to Trimethoprim sulfamethoxazole, sulfonamides antibiotics, G6PD deficiency, or any component of the formulation <input type="checkbox"/> Pregnancy during 1 st Trimester or after 32 weeks, infant <2 months <input type="checkbox"/> Do Not use in patient with megaloblastic anemia from folate deficiency or H=hyperkalemia				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Avoid if baby has G6PD Def, Jaundice			Class D- not in 1st trimester	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Rash/ Itching <input type="checkbox"/> Take with 8 oz of water				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Antibiotic against aerobic gram positive and gram negative bacteria <input checked="" type="checkbox"/> Inhibits bacterial folic acid synthesis and growth				

Valacyclovir*	TRADE NAME			
	Valtrex			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
	ADTMC Drug Instructions		Additional Drug Information	
	2 grams	Oral	NA	NA
	Take 2 g twice 12 hours apart		NA	
	Additional Drug Information		Additional Drug Information	
1-2g	Oral	20mg/kg	Oral	
Cold sores: 2 g twice every 12 hours HSV (initial): 1 g twice a day x10 days HSV (recurrent): 1 g daily x5 days		Varicella >2 y/o: 20 mg/ kg three times per day x 5 days (Maxi: 1 g/ dose)		
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to valcyclovir, acyclovir, or any component of the formulation				
SAFETY IN LACTATION		SAFETY IN PREGNANCY		
Use Caution; Enters Milk		CLASS B– Presumed Safe		
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Headache, confusion, agitation <input type="checkbox"/> Nausea, abdominal pain				
MECHANISM OF ACTION				
✓ Converts to Acyclovir ✓ Inhibits DHA synthesis and viral replication				

DIPHENHYDRAMINE	TRADE NAME	
	Benadryl	
INDICATIONS	ADULT	
	DOSE	ROUTE
Allergies Hives Motion Sickness	ADTMC Drug Instructions	
	25 mg	PO
Anaphylactic Reaction	Take 1 tablet every 8 hrs or at bedtime	
	50 mg	IV
		PEDIATRIC (< 12 years)
		DOSE
		ROUTE
		Additional Drug Information
		1.25 mg/ kg PO / IM
		2-5 y/o: 6.25 mg every 6 hrs 6-12 y/o: 12.5-25 mg every 6 hrs
		1.25 mg/ kg IV
		ASAP after 0.15 mg IM epinephrine (Maximum: 50 mg dose)
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to diphenhydramine or any component of the formulation <input type="checkbox"/> Acute Asthma <input type="checkbox"/> Use on Neonates, premature infants, Nursing mothers		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
UNSAFE	CLASS B - PRESUMED SAFE	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Normally causes sedation, but may cause paradoxical excitation <input type="checkbox"/> May have increased sedative effects when used with other sedatives or alcohol <input type="checkbox"/> May cause hypotension (use with caution in patient with cardiovascular disease) <input type="checkbox"/> Dry mouth and may increase risk of heat injury		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Competes with histamine for H1-receptor sites within the gastrointestinal tract, blood vessels, and respiratory tract. <input checked="" type="checkbox"/> Produces anticholinergic and sedative effects		

LORATADINE	TRADE NAME			
	Claritin			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
Seasonal Allergies Hives	ADTMC Drug Instructions		Additional Drug Information	
	10 mg	Oral	NA	NA
	Take 1 tab daily for allergies			
	Additional Drug Information		Additional Drug Information	
	10 mg	Oral	5 mg	Oral
Take 1 tab daily for allergies or hives		2-5 y/o: 5 mg once daily for allergies 6+ y/o: use adult dosing		
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to loratadine or any component of the formulation				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Use Caution- Monitor			Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Headache <input type="checkbox"/> Sedation and may have increased sedative effects when used with other sedatives or alcohol <input type="checkbox"/> In breast fed infant, monitor for drowsiness, irritability, agitation <input type="checkbox"/> May increase risk of heat injury				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Competes with histamine for H1-receptor sites within the gastrointestinal tract, blood vessels, and respiratory tract. <input checked="" type="checkbox"/> Second Generation, Less sedating than First Generation (diphenhydramine)				
AVIATION CONSIDERATIONS				
<input checked="" type="checkbox"/> Short term use by individual aircrew is authorized but the aircrew member must report use of this medication to the FS/APA as soon as possible. FS/APA should be concerned not only with the use of this medication but also the underlying problem that the individual is self-treating (for example, allergic rhinitis) and the aeromedical implications of the diagnosis.				

RANITIDINE**	TRADE NAME			
	Zantac			
INDICATIONS Heartburn Gastroesophageal Reflux Disease (GERD) Erosive Esophagitis	ADULT		PEDIATRIC (< 16 years)	
	DOSE	ROUTE	DOSE	ROUTE
	ADTMC Drug Instructions		Additional Drug Information	
	150 mg	Oral	75 mg	Oral
	Take 1 tab twice a day as needed for heartburn		75-150 mg 30 min before eating up to 2x/ day (max: 14 days)	
Additional Drug Information		Additional Drug Information GERD <16yrs old		
150 mg	Oral	5-10 mg/ kg/ day	Oral	
Take 1 tab 1-4 times daily as needed for GERD or Erosive Esophagitis		Divided into 2 doses 12 hrs apart (Maximum: 300 mg/ day)		
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to ranitidine or any component of the formulation				
SAFETY IN LACTATION		SAFETY IN PREGNANCY		
Unknown		CLASS B- Presumed Safe		
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Vitamin B12 deficiency when used for over 2 years				
MECHANISM OF ACTION				
<ul style="list-style-type: none"> ✓ Competes with histamine for H2-receptor sites within the gastrointestinal tract ✓ Inhibits gastric acid secretion and gastric volume 				

BENZOCAINE 15 mg, MENTHOL 3.6 mg Lozenge	TRADE NAME	
	Cepacol Lozenge	
INDICATIONS	ADULT	
	DOSE	ROUTE
Sore Throat Mouth Irritation	ADTMC Drug Instructions	
	1 Lozenge	Oral
	Allow 1 lozenge to dissolve slowly in mouth every 2 hours as needed	
	Additional Drug Information	
	1 Lozenge	Oral
	Every 2 hours as needed for sore throat	
	PEDIATRIC (< 12 years)	
	DOSE	ROUTE
	Additional Drug Information	
	1 Lozenge	Oral
	>5 years old: Refer to Adult Dosing	
	NA	NA
	NA	
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to benzocaine, para-aminobenzoic acid (PABA), or any component of the formulation <input type="checkbox"/> Children <5 years old, asthma, G6PD Deficiency due to risk of methemoglobinemia		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unsafe	Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Methemoglobinemia: blue lips/ nails, dizziness, headache, lethargy, shortness of breath		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Blocks the initiation and conduction of nerve impulses <input checked="" type="checkbox"/> Decreases the neuronal membrane's sodium ion permeability		
AVIATION CONSIDERATIONS		
<input checked="" type="checkbox"/> Acceptable provided the lozenge contains no prohibited medication. Benzocaine (or similar analgesic) containing throat spray or lozenge is acceptable. Long term use (more than 3 days) must be approved by the local flight surgeon.		

OXYMETAZOLINE** (Decongestant)	TRADE NAME	
	Afrin	
INDICATIONS	ADULT	
	DOSE	ROUTE
Nasal Congestion Nosebleed	ADTMC Drug Instructions	
	0.05% spray	Nasal
	2 sprays in affected side twice a day for 3 days	
	Additional Drug Information	
	2-3 sprays	Nasal
	2-3 sprays in affected side twice daily for up to 3 days (Max: 2 doses/ 24 hours)	
	Additional Drug Information	
	NA	NA
	NA	
	PEDIATRIC (< 12 years)	
	DOSE	ROUTE
	Additional Drug Information	
	2 sprays	Nasal
	Children >6 years: Refer to Adult Dosing	
	Additional Drug Information	
	NA	NA
	NA	
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to oxymetazoline or any component of its formulation <input type="checkbox"/> Child 5 years old or younger- ingestion can cause coma, bradycardia, respiratory depression, sedation		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown	Unknown, Chronic Use Unsafe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Rebound nasal congestion from use >3 days <input type="checkbox"/> Nasal irritation, burning		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Stimulates alpha-adrenergic receptors causing vasoconstriction		
AVIATION CONSIDERATIONS		
<input checked="" type="checkbox"/> Long-acting nasal sprays are restricted to no more than 3 days. Use of oxymetazoline for longer than the above time must be validated and approved by a flight surgeon. Recurrent need for nasal sprays must be evaluated by the flight surgeon. Use requires the aircrew member to be free of side effects.		

PSEUDOEPHEDRINE* (Decongestant)	TRADE NAME	
	Sudafed	
INDICATIONS	ADULT	
	DOSE	ROUTE
Nasal Congestion	ADTMC Drug Instructions	
	30 mg	Oral
	Take 2 tab every 6 hours as needed for congestion	
	Additional Drug Information	
	30 mg, 120 mg	Oral
	Take 60 mg every 4-6 hrs as needed for congestion Take 120 mg extended release every 12 hrs as needed for congestion	
	Additional Drug Information	
	15 mg	Oral
	4-5 years old: 15 mg every 4-6 hrs as needed for congestion	
	Additional Drug Information	
	30 mg	Oral
	6-11 years old: 30 mg every 4-6 hours as needed for congestion	
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to pseudoephedrine or any component of its formulation <input type="checkbox"/> Children <4 years old <input type="checkbox"/> Administering with or within 2 weeks of taking a MAO Inhibitor <input type="checkbox"/> Hypertension, Ischemic heart disease, Diabetes, Seizure disorder		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Use Caution; Enters Milk		Unsafe
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Palpitations, hypertension, tachycardia <input type="checkbox"/> Insomnia, feeling jittery <input type="checkbox"/> Urinary retention <input type="checkbox"/> Increased risk of heat injury		
MECHANISM OF ACTION		
✓ Stimulates alpha-adrenergic receptors causing vasoconstriction		
AVIATION CONSIDERATIONS		
✓ When used for mild nasal congestion in the presence of normal ventilation of the sinuses and middle ears (normal valsalva). Must notify supervising provider that patient is on flight status when requesting prescription.		

GUAIFENESIN (Expectorant)	TRADE NAME			
	Mucinex Childrens, Robitussin, Tussin			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
Cough	ADTMC Drug Instructions		Additional Drug Information	
	100 mg/ 5 mL	Oral	50-100mg	Oral
	1 tablespoon (15 mL) every 6 hours as needed for excess mucous (Max: 8 tablespoons/ 24 hours)		2-3 years old: 50 mg every 4hr as needed 4-5 years old: 100 mg every 4hrs as needed (Maximum: 600 mg/ 24hrs)	
	Additional Drug Information Extended Release		Additional Drug Information 6-11 years old	
600 mg	Oral	100-200 mg	Oral	
1-2 tabs every 12 hours as needed for excess mucous (Max: 2400 mg/ 24 hours)		Every 4 hrs as needed (Maximum: 1,200 mg/24 hrs)		
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to guaifenesin or any component of the formulation <input type="checkbox"/> Do Not use extended release tablets in children under 12 years old <input type="checkbox"/> Chronic cough productive for phlegm				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Unknown			Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Dizziness, drowsiness				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Increase the hydration of the respiratory tract, thus decreasing viscosity of respiratory mucous <input checked="" type="checkbox"/> Inhibits the cough reflex sensitivity in subjects with upper respiratory tract infections				
AVIATION CONSIDERATIONS				
<input checked="" type="checkbox"/> Must just be guaifenesin. Many OTC cough syrups contain sedating antihistamines or Dextromethorphan (DM) and are prohibited for aviation duty.				

POLYETHYLENE GLYCOL** (Bulking Agent)	TRADE NAME	
	Miralax	
INDICATIONS	ADULT	
	DOSE	ROUTE
Constipation Hemorrhoids Anal Fissure	ADTMC Drug Instructions	
	17 grams	Oral
	17 g (1 heaping tablespoon) in 4-8 ounces of beverage daily (Maximum: 2 weeks)	
	Additional Drug Information	
	17 g	Oral
17 g daily in 4-8 ounces of beverage		
PEDIATRIC (< 17 years)		
DOSE	ROUTE	
Additional Drug Information		
0.2-1 g/ kg	Oral	
Daily dose titrated to effect (Max: 17 g/ day)		
Additional Drug Information		
NA	NA	
NA		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to polyethylene glycol or any component of the formulation <input type="checkbox"/> Suspected bowel obstruction (symptoms of nausea, vomiting, abdominal pain or distension) <input type="checkbox"/> Renal impairment/ kidney disease due to risk of electrolyte imbalance		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown	Unknown	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Nausea, diarrhea, gas, stomach cramping, stomach bloating		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Osmotic agent causes water retention in the stool increasing stool frequency and decreasing stool consistency		

DOCUSATE SODIUM** (Stool Softener)	TRADE NAME	
	Colace	
INDICATIONS	ADULT	
	DOSE	ROUTE
Constipation Hemorrhoids Anal Fissure	ADTMC Drug Instructions	
	100 mg	Oral
	Take 1 capsule twice a day (Maximum: 7 days of use)	
	Additional Drug Information	
	50-360 mg	Oral
50-360 mg daily or in divided doses		
Additional Drug Information		
50-150 mg		Oral
Age 2-11: Once daily or in divided doses		
Additional Drug Information		
NA		NA
NA		NA
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to docusate sodium or any component of the formulation <input type="checkbox"/> Children under the age of 2		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown	Not Preferred	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Ensure adequate fluid intake		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Reduces surface tension of stool resulting in increased absorption of water and fat into stool		

LOPERAMIDE*	TRADE NAME	
	Imodium	
INDICATIONS	ADULT	
	DOSE	ROUTE
Diarrhea	ADTMC Drug Instructions	
	2 mg	Oral
	Take 2 tabs and then 1 tab after each loose stool as needed (Maximum: 8 mg/ 4 tabs)	
	Additional Drug Information	
2 mg	Oral	
4 mg now and 2 mg after each loose stool (Maximum: 16 mg/ 8 tabs)		
Additional Drug Information		
PEDIATRIC (< 13 years)		
DOSE	ROUTE	
Additional Drug Information First 24 hours		
1 mg	Oral	
2-5 yrs (13-20 kg): 1 mg three times per day 6-8 yrs (20-30 kg): 2 mg twice a day 8-12 yrs (>30 kg): 2 mg three times per day		
After First 24 hours		
0.1 mg/ kg	Oral	
Dose after each loose stool Maximum dose: 2-5yrs: 3 mg/ day 6-8yrs: 4 mg/ day 8-12: 6 mg/ day		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to loperamide or any component of the formulation <input type="checkbox"/> Doses higher than recommended can cause heart arrhythmia (Torsades de Pointes) and death <input type="checkbox"/> Children under 2 years of age <input type="checkbox"/> Dysentery, abdominal pain, ulcerative colitis, bacterial enterocolitis, antibiotic associated diarrhea		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Not Recommended		CLASS C– Potential Harm
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Constipation, abdominal cramps, nausea <input type="checkbox"/> Dizziness, drowsiness		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Anti-diarrheal <input checked="" type="checkbox"/> Inhibits peristalsis of intestinal muscles resulting in prolonged stool transit time and increased stool viscosity		

BISACODYL ** (Laxative)	TRADE NAME	
	Dulcolax	
INDICATIONS	ADULT	
	DOSE	ROUTE
Constipation	ADTMC Drug Instructions	
	5 mg	Oral
	Take 1-2 tabs daily (Maximum: 1 week use)	
	Additional Drug Information	
	5 mg	Oral
	Take 1-3 tabs daily	
PEDIATRIC (< 12 years)		
DOSE		
ROUTE		
Additional Drug Information		
5mg		
Oral		
6-11 years old: 5 mg daily		
Additional Drug Information		
NA		
NA		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to bisacodyl or any of its components <input type="checkbox"/> Signs of intestinal obstruction or bowel perforation: nausea, vomiting, pain, distension, abdominal rigidity		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown	CLASS B- Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Abdominal cramps, Abdominal pain, nausea, vomiting, headache <input type="checkbox"/> Do Not take within 1 hour of antacids, milk, or dairy products <input type="checkbox"/> Swallow the tab whole		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Stimulated peristalsis by irritating the smooth muscles of the intestines and increases fluid accumulation in the intestines		

BISMUTH SUBSALICYLATE	TRADE NAME			
	Maalox, Pepto-Bismol			
INDICATIONS	ADULT	PEDIATRIC (< 12 years)		
	DOSE	ROUTE	DOSE	ROUTE
Diarrhea	ADTMC Drug Instructions		Additional Drug Information	
	262 mg/ 15 mL	Oral	NA	NA
Indigestion	Take 30 mL every hour as needed for up to 2 days (Maximum: 8 doses/ 24 hours)		NA	
	Additional Drug Information		Additional Drug Information	
	524 mg	Oral	NA	NA
	Take 1 dose every 30 min as needed (Maximum: 4,200 mg (8 doses))		NA	
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to salicylates or taking other salicylates <input type="checkbox"/> History of stomach ulcer, bleeding problem, black or bloody stools <input type="checkbox"/> Children recovering from chickenpox or flu-like symptoms due to risk of Reye syndrome				
SAFETY IN LACTATION		SAFETY IN PREGNANCY		
Unsafe		Unsafe		
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Anxiety, confusion, tinnitus <input type="checkbox"/> Shake well prior to use (liquid), chew tablets well before swallowing (chewable tablets) <input type="checkbox"/> Can turn stools or tongue black				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Salicylate has an antisecretory action. <input checked="" type="checkbox"/> Bismuth has an antimicrobial activity against bacterial and viral gastrointestinal pathogens.				
AVIATION CONSIDERATIONS				
<input checked="" type="checkbox"/> Antacid (Maalox): When used occasionally or infrequently. Chronic use is Class 3. <input checked="" type="checkbox"/> Pepto Bismol: If used for minor diarrhea conditions and free of side effects for 24 hours.				

ALBUTEROL *	TRADE NAME			
	Proventil, Ventolin			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
Bronchospasm	ADTMC Drug Instructions		Additional Drug Information	
	90 mcg/ puff	INHALER	90 mcg/ puff	INHALER
	2 puffs every 6 hours as needed		4-8 puffs every 20 min for 3 doses; then every 1-4 hr as needed	
	Additional Drug Information		Additional Drug Information	
	5.0 mg	NEBULIZER	2.5-5.0 mg	NEBULIZER
	Every 6 hours as needed		Every 4-8 hours as needed	
Acute Asthma Exacerbation	90 mcg/ puff	INHALER	90 mcg/ puff	INHALER
	4 puffs every 20 min for up to 4 hr; then every 2 hr as needed		4-8 puffs every 20 min for 3 doses; then every 1-4 hr as needed	
	2.5-5.0 mg	NEBULIZER	2.5 mg	NEBULIZER
	Every 20 min for 3 doses; then 2.5-10 mg every 1-4 hrs as needed OR 10-15 mg/ hour continuous		Every 20 min for 3 doses; then 0.15-0.3 mg/ kg every 1-4 hr as needed (Maximum:10 mg) OR 0.5 mg/ kg/ hour continuous	
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to albuterol or any component of the formulation <input type="checkbox"/> Symptomatic tachycardia				
SAFETY IN LACTATION		SAFETY IN PREGNANCY		
Unknown		CLASS C – UNCERTAIN SAFETY		
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Risk of abortion during 1st or 2nd trimester <input type="checkbox"/> Headache, Dizziness, Flushing, Diaphoresis, Tremor, Weakness, Angina, A-Fib, Arrhythmia, Chest pain, Palpitations, Dyspnea, Bronchospasm in asthmatics				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Beta2 Agonist (Bronchodilator) <input checked="" type="checkbox"/> Synthetic sympathomimetic that relaxes bronchial smooth muscle, causing bronchodilation, with little cardiac impact.				

ACETYLSALICYLIC ACID*	TRADE NAME	
	Aspirin, Bayer	
INDICATIONS	ADULT	
	DOSE	ROUTE
Acute Coronary Syndrome	ADTMC Drug Instructions	
	81 mg	Oral
Unstable Angina	Chew 4 nonenteric coated baby aspirin in a single dose (4 x 81 mg)	
	Additional Drug Information	
Non-ST Segment Elevated Myocardial Infarction	81 mg	Oral
	Chew 4 nonenteric coated baby aspirin in a single dose (4 x 81 mg)	
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to salicylates, other NSAIDs, or any component of the formulation <input type="checkbox"/> Asthma, Rhinitis <input type="checkbox"/> History of stomach ulcer, bleeding problem, black or bloody stools <input type="checkbox"/> Children recovering from chickenpox or flu-like symptoms due to risk of Reye syndrome		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown	CLASS D- Unsafe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Not for use on trauma patients in the combat environment. <input type="checkbox"/> Risk of bleeding: Avoid use in patients with known or suspected, Bleeding disorders, GI Bleed, GI Ulcers, patients taking Coumadin, or within 24hrs of taking Alteplase (tPA) for suspected stroke		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Blocks cyclooxygenase (COX 1 and 2) enzymes, resulting in reduced formation of prostaglandin precursors. <input checked="" type="checkbox"/> Blocks formation of prostaglandin derivative, thromboxane A2, resulting in inhibited platelet aggregation. <input checked="" type="checkbox"/> Antipyretic, analgesic, and anti-inflammatory properties.		

EPINEPHRINE*	TRADE NAME	
	EpiPen	
INDICATIONS	ADULT	
	DOSE	ROUTE
Anaphylactic Reaction	ADTMC Drug Instructions	
	1 EpiPen	IM
	Inject 1 epi pen into thigh and may repeat in 10 min if not improved; follow with diphenhydramine 50 mg IV and transport to emergency care	
	Additional Drug Information	
	0.3-0.5 mg	IM/IV
Every 5-15 min until improvement; follow with diphenhydramine 50 mg IV		
Additional Drug Information		
NA		NA
NA		NA
CONTRAINDICATIONS		
<input type="checkbox"/> Uncontrolled hypertension is a relative contraindication in more mild reactions		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Unsafe		CLASS C- Unknown Safety
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Chest Pain, Tachycardia, Arrhythmias, Palpitations, Sudden death <input type="checkbox"/> Anxiety, Cerebral Hemorrhage, Headache		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Sympathomimetic, stimulates both alpha and beta adrenergic receptors, causing relaxation of the bronchial tree, cardiac stimulation (increasing myocardial oxygen consumption), and dilation of skeletal muscle blood vessels		

GLUCAGON*	TRADE NAME	
	GlucaGen / Glucagon Emergency Kit	
INDICATIONS	ADULT	
	DOSE	ROUTE
<p>Esophageal Food Impaction</p> <p>Hypoglycemia</p>	ADTMC Drug Instructions	
	1 mg	IV
	Inject 1 mg IV with 10 cc Normal Saline flush For Hypoglycemia, follow with Dextrose IV and may repeat once in 20 minutes	
	Additional Drug Information	
	1 mg	IM/IV
Every 20 minutes as needed Hypoglycemia, give IV dextrose ASAP		
Additional Drug Information		
PEDIATRIC (< 12 years)		
DOSE	ROUT	
Additional Drug Information		
NA	NA	
NA		
Additional Drug Information		
0.5 mg	IV/IM	
Every 20 min as needed Adult dosing if over 20 kg		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to glucagon or any component of the formulation <input type="checkbox"/> Insulinoma <input type="checkbox"/> Pheochromocytoma		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Safe		CLASS B- Presumed Safe
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Should <i>NOT</i> be used as 1st line treatment for Hypoglycemia, AMS, or Food Bolus Impaction <input type="checkbox"/> Hypoglycemia patients should receive dextrose. If IV access cannot be established or if dextrose is not available, glucagon may be used as alternate until dextrose can be given. <input type="checkbox"/> Thiamine should precede use in patient with suspected alcoholism or malnutrition		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Raises blood glucose levels by stimulating increased production of cyclic AMP <input checked="" type="checkbox"/> Promotes hepatic gluconeogenesis		

CALAMINE LOTION**	TRADE NAME			
	Caladryl, Calagesic			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
	ADTMC Drug Instructions		Additional Drug Information	
Contact Dermatitis	Dab	Topical	Dab	Topical
Insect Bite	Clean and dry area. Cover affected area and let dry. Repeat every 6 hours as needed for itching.		Apply to the affected area every 6 hours as needed for itching.	
	Additional Drug Information		Additional Drug Information	
	Dab	Topical	NA	NA
	Apply as often as needed for itching.		NA	
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to Calamine, zinc oxide, or any of its components <input type="checkbox"/> Children less than 2 unless prescribed by a provider				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Presumed Safe- Not on Breast			Presumed Safe	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Hives, Irritation, Allergic Reaction <input type="checkbox"/> Shake well before use. <input type="checkbox"/> Avoid contact with eyes, mucous membranes, burns, or open wounds				
MECHANISM OF ACTION				
✓ Astringent and skin protectant properties to relieve itching.				

ALUMINUM ACETATE**	TRADE NAME	
	Domeboro's Solution, Boro-Packs, Pedi-Boro	
INDICATIONS	ADULT	
	DOSE	ROUTE
Contact Dermatitis Skin Irritation	ADTMC Drug Instructions	
	1 packet	Topical
	1 packet/ 16 ounces water Soak area or apply compress for 30 minutes. Repeat every 8 hours as needed 1 Boro-Pack= 0.16%	
	Additional Drug Information	
	1 soak	Topical
Soak area every 8 hours as needed. Apply compress for 15-30 min as needed for itching. 1-3 packets/ 16 ounces water (depending on brand)		
PEDIATRIC (< 12 years)		
	DOSE	ROUTE
Additional Drug Information		
	1-3 pkts	Topical
1-3 packets/ 16 ounces water Soak area every 8 hours as needed Compress x15-30 minutes as needed for itching 1 Pedi-Boro packet= 0.13%		
Additional Drug Information		
	NA	NA
NA		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to aluminum acetate or any component of the formulation		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown	Unknown	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Irritation or Rash <input type="checkbox"/> Avoid contact with eyes, mucous membranes		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Astringent properties to relieve itching		

PROPYLENE GLYCOL ** <i>(Artificial Tears)</i>	TRADE NAME	
	Systane Balance	
INDICATIONS	ADULT	
	DOSE	ROUTE
Dry Eyes	ADTMC Drug Instructions	
	1-2 drops	Ophthal
	Apply 1-2 drops in affected eye every hour as needed	
	Additional Drug Information	
	1-2 drops	Ophthal
	Apply 1-2 drops in affected eye as needed for symptoms	
	Additional Drug Information	
	NA	NA
	NA	
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to any components of the formulation.		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Safe	Safe	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Mild stinging of eye, eyelid crusting, or blurred vision. <input type="checkbox"/> Remove contact lenses prior to use. <input type="checkbox"/> Do not touch tip of applicator to any surface to avoid contamination.		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Demulcents have protection and lubrication properties.		
AVIATION CONSIDERATIONS		
<input checked="" type="checkbox"/> Saline or other lubricating solution only. Visine or other vasoconstrictor agents are prohibited for aviation duty.		

HYDROCORTISONE VALERATE**	TRADE NAME	
	Westcort Cream	
INDICATIONS	ADULT	
	DOSE	ROUTE
Irritant Dermatitis Contact Dermatitis Skin Inflammation/ Irritation	ADTMC Drug Instructions	
	1%	Topical
	Apply a thin film twice a day as needed for itching or inflammation (Max: 2 weeks)	
	Additional Drug Information	
	1%	Topical
	Apply a thin film 2-3 time per day as needed for itching or inflammation	
	Additional Drug Information	
	NA	NA
	NA	
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to hydrocortisone or any component of its formulation. <input type="checkbox"/> OTC hydrocortisone is not labeled for use in children under 2 years old. <input type="checkbox"/> Diffuse areas larger than patient's hands, occlusive dressing, heating source can result in increased doses. <input type="checkbox"/> Adrenal suppression can progress to adrenal crisis.		
SAFETY IN LACTATION	SAFETY IN PREGNANCY	
Unknown- Considered Safe	Class C– Potential for Harm	
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Skin atrophy, atrophic striae, hypopigmentation, burning sensation <input type="checkbox"/> Secondary skin infection		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Anti-inflammatory, anti-pruritic, and vasoconstrictive properties <input checked="" type="checkbox"/> Induces phospholipase A ₂ inhibitory proteins and inhibits the release of arachidonic acid decreasing the mediators of inflammation.		

ACETIC ACID (AA) AND HYDROCORTISONE (HC)* **	TRADE NAME	
	Acetasol HC	
INDICATIONS	ADULT	
	DOSE	ROUTE
Otitis Externa	ADTMC Drug Instructions	
	AA2%, HC1%	Otic
	5 drops in affected ear(s) every 6 hours	
	Additional Drug Information	
AA2%, HC3%		Otic
>3 years old: 3-5 drops in affected ear every 4-6 hrs while cotton wick inserted (24 hrs) 5 drops in affected ear every 6-8 hrs daily after 24 hours		
Additional Drug Information		
NA		NA
NA		NA
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to acetic acid, propylene glycol, hydrocortisone or any components of the formulation <input type="checkbox"/> Perforated tympanic membrane <input type="checkbox"/> HSV or varicella infection <input type="checkbox"/> Local reaction/ irritation develops		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Unknown- Considered Safe		Class C– Potential for Harm
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Stinging of ear, burning sensation <input type="checkbox"/> Local irritation		
MECHANISM OF ACTION		
<input checked="" type="checkbox"/> Acetic acid has bacteriostatic and fungistatic properties. <input checked="" type="checkbox"/> Hydrocortisone has anti-inflammatory, anti-pruritic, and vasoconstrictive properties. <input checked="" type="checkbox"/> Hydrocortisone induces phospholipase A ₂ inhibitory proteins and inhibits the release of arachidonic acid decreasing the mediators of inflammation.		

HYDROCORTISONE 2.5% AND PRAMOXINE 1%* **	TRADE NAME			
	Analpram-HC			
INDICATIONS	ADULT		PEDIATRIC (< 12 years)	
	DOSE	ROUTE	DOSE	ROUTE
Hemorrhoid Anal Itching	ADTMC Drug Instructions		Additional Drug Information	
	1 Dab	Topical	NA	NA
	Apply to clean, dry area 4 times/ day (Maximum: 1 week)		NA	
	Additional Drug Information		Additional Drug Information	
		1 Dab	Topical	NA
		Apply to clean, dry area 4 times/ day		NA
CONTRAINDICATIONS				
<input type="checkbox"/> Hypersensitivity to hydrocortisone, pramoxine, or any component of the formulation <input type="checkbox"/> Caution when used in patients with heart disease or diabetes <input type="checkbox"/> Not approved for use in children <12 years old <input type="checkbox"/> Adrenal suppression can progress to adrenal crisis				
SAFETY IN LACTATION			SAFETY IN PREGNANCY	
Unknown- Not Recommended			CLASS C – Potential for Harm (Hydrocortisone)	
ADVERSE REACTIONS/PRECAUTIONS				
<input type="checkbox"/> Skin atrophy, atrophic striae, hypopigmentation, burning sensation <input type="checkbox"/> Secondary skin infection				
MECHANISM OF ACTION				
<input checked="" type="checkbox"/> Hydrocortisone has anti-inflammatory, anti-pruritic, and vasoconstrictive properties <input checked="" type="checkbox"/> Pramoxine is an anesthetic that interferes with pain signals sent from the nerves to the brain.				

RETINOID CREAM* ** (ADAPALENE)	TRADE NAME	
	Differin Cream, 0.1% Gel is OTC	
INDICATIONS	ADULT	
	DOSE	ROUTE
Acne	ADTMC Drug Instructions	
	0.1%	Topical
	Apply a thin film once daily at bedtime (nickel size amount for entire face)	
	Additional Drug Information	
	0.1-0.3%	Topical
Apply a thin film once daily at bedtime		
PEDIATRIC (< 12 years)		
DOSE		ROUTE
Additional Drug Information		
NA	NA	
NA		
Additional Drug Information		
NA	NA	
NA		
CONTRAINDICATIONS		
<input type="checkbox"/> Hypersensitivity to adapalene or any component of the formulation <input type="checkbox"/> Not approved for children under 12 years old <input type="checkbox"/> Avoid contact with mucous membranes (eyes, nose, mouth, vaginal, and anal mucosa) <input type="checkbox"/> Avoid contact with broken, eczematous, or sunburned skin		
SAFETY IN LACTATION		SAFETY IN PREGNANCY
Unknown		CLASS C – Potential Harm
ADVERSE REACTIONS/PRECAUTIONS		
<input type="checkbox"/> Dry skin, redness, burning or stinging of the skin, skin peeling <input type="checkbox"/> Skin itching <input type="checkbox"/> Increased susceptibility to sunburn		
MECHANISM OF ACTION		
✓ Modulates cellular differentiation, keratinization, and the inflammatory process		

Appendix D Screening Note

1. To ensure appropriate documentation of Soldier care, screeners will use MHS EHR Common Core TSWF Form or equivalent MHS EHR form to record the use of ADTMC in MTFs. The form will be a permanent part of the Soldier's health record. Use of MHS EHR Common Core TSWF Form or equivalent MHS EHR form is mandatory, if available. If access to the MHS EHR is not available, then the ADTMC screener may use DA Form 5181, in accordance with AR 40-66, and upload the document in the MHS EHR as soon as feasible.

2. DA Form 5181 is available electronically through the Army Medical Department (AMEDD) E-Forms Program. A copy for local reproduction is at the end of this appendix if electronic forms are not available.

3. Special instructions.

a. Vital signs will be recorded with every encounter to include temperature, heart rate, blood pressure, respiratory rate, SpO₂, and pain level.

b. Soldier will be consented if the visit will be conducted as a virtual health visit.

c. Chief complaint, history of present illness, current medications, medication allergies, last menstrual period for all females, and MRC status with any delinquent readiness requirements will be recorded with every encounter in a SOAP-D format. MRC status and delinquent examinations may be excluded if access to the electronic record is not readily available. If the MHS EHR Common Core TSWF Form or equivalent MHS EHR form is not available, it will be documented at the top of the protocol summary section on DA Form 5181.

d. Algorithm/Code. Using the Soldier's chief complaint, enter the protocol code in parentheses following the protocol title (for example, headache, F-2) under the history of present illness section of the subjective section of the note. If the MHS EHR is not available, it will be documented in the algorithm/code section of DA Form 5181. If the Soldier presents two related chief complaints, the more serious of the two must be determined and the appropriate protocol utilized. When two complaints appear to be unrelated or if the screener is unable to determine the more serious of the two, each complaint will be screened separately utilizing both spaces.

e. Protocol summary. Following the flow chart for the selected protocol, the screener will summarize--by numbered narrative statements--the question and answer for each box number until an end-point is reached. Summary will include all pertinent positive and negative Soldier responses. In certain instances, the logic may involve skipping one or more boxes. In this case, DO NOT enter a response for any boxes skipped.

f. Comments. If the protocol disposition results in a “Provider Now” or “AEM Now”, the screener may gather more subjective data, examine the Soldier where appropriate, and make a tentative assessment after the privileged provider or AEM has been notified of the Soldier. There must be evidence of the direct involvement of the privileged provider or AEM. The privileged provider or AEM must physically evaluate the Soldier, confirm the screener’s data, independently assess the Soldier’s complaint, and direct the plan of care. Privileged provider’s or AEM’s evaluation will be documented in the MHS EHR Common Core TSWF Form or equivalent MHS EHR form and be signed by privileged provider or AEM. If signed by the AEM, the supervising privileged provider must cosign the evaluation. The MHS EHR Common Core TSWF Form or equivalent MHS EHR form requires the full screening documentation at this time. In the case where access to the MHS EHR is not available, the privileged provider will hand write his or her note on the DA Form 5181 in the comments section.

g. Final disposition. Check the care category or level indicated by the protocol endpoint. If an MCP is called for, the screener will enter the protocol number. The screener will enter the disposition to include any treatments and counseling provided to the Soldier in the “comments” section. If two protocols are used and the endpoints direct the Soldier to different care categories or levels, the screener will enter the higher category or level. If two protocols are used and the endpoints direct the screener to provide different treatment regimens, the screener will provide both treatment regimens to the Soldier and notify the NCO of his or her actions prior to the Soldier leaving the screening area.

h. Record of acute medical care (reverse side). Entries in this section are for use by a privileged provider for documentation of further evaluation and treatment of complaints previously screened in place of a SF 600 (Chronological Record of Medical Care).

4. This form will accompany the Soldier to the next level of care and be a part of the health record when evaluation and audits are completed.

SCREENING NOTE OF ACUTE MEDICAL CARE			
For use of this form, see AR 40-88; the proponent agency is the Office of The Surgeon General.			
TIME PATIENT DEPARTS UNIT <i>(From DD Form 689)</i>		SCREENER LOCATION	
		TIME PATIENT ARRIVES	TIME ENCOUNTER BEGINS
		TIME PATIENT LEAVES	
DATE (YYYY/M/DD)	SCREENER LOCATION	CHIEF COMPLAINT	DURATION
PATIENT RESIDENCE <input type="checkbox"/> BARRACKS <input type="checkbox"/> POST HOUSING <input type="checkbox"/> OFF POST <input type="checkbox"/> TRANSIENT		VITAL SIGNS TEMPERATURE _____ ALLERGIES _____ PULSE _____ BP _____ RESP _____	
FIRST VISIT FOR THIS COMPLAINT <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, WAS RETURN SCHEDULED/REQUESTED BY CARE PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ALGORITHM/CODE		ALGORITHM/CODE	
ALGORITHM SUMMARY		ALGORITHM SUMMARY	
COMMENTS <i>(Reasons for referral, method of referral, hospital appointments, self-care protocols, and patient instructions/precautions)</i>			
PATIENT'S IDENTIFICATION <i>(Use mechanical report if available, for typed or written entries give: Name, SSN, Unit, Sex, Birthdate and Duty Phone)</i>		FINAL DISPOSITION <input type="checkbox"/> I - PHYSICIAN STAT <input type="checkbox"/> IV - SELF CARE PROTOCOL <input type="checkbox"/> II - PA STAT <input type="checkbox"/> V - HOSP CLINIC REFERRAL <input type="checkbox"/> III - PA	
		AIDMAN'S SIGNATURE & CODE	AUDITOR'S INITIALS & DATE (YYYY/M/DD)

Appendix E

Safety and quality control protocol

1. As part of a high reliability organization's continuum of medical care, the ADTMC protocol will have a safety and quality control plan. The key components of the ADTMC protocol orientation and competency validation training program are: MHS EHR documentation using a team approach to care, care reviews by screening peers, supervising NCOs, and supervising privileged providers, and active preceptorship with continual feedback.

2. ADTMC protocol orientation and competency validation training program will encompass a cumulative four week clinical validation time period that incorporates 36 hours of didactic instruction.

a. Didactic instruction is focused on further developing the medic's foundation of clinical knowledge in common medical conditions encountered within primary care.

b. Clinical validation time period supplements the instruction through clinical experience while working within a military treatment facility and provides an opportunity for the supervising privileged provider to validate the medic's clinical competencies.

c. After completion of the minimum 4 week cumulative validation time period, the supervising privileged provider may delegate the ADTMC protocol authorization through a memorandum for record (MFR) that is kept within the Soldier's CAF and uploaded into his or her Joint Centralized Credentials and Quality Assurance System (JCCQAS) account.

d. All medics must be entered into JCCQAS for clinical competency tracking.

e. Clinical competencies must be revalidated at least every two years or upon working in a new clinical setting. Clinical competencies may be revalidated earlier if a decline in a screening medic's competency is identified and deemed necessary by the supervising privileged provider or supervising NCO.

f. ADTMC protocol orientation and competency validation training program is discussed further in appendix G.

3. Documentation of Soldier screenings will be within the MHS EHR TSWF Core Form or DA Form 5181 when access to the MHS EHR is not available in accordance with AR 40-66, and uploaded in the MHS EHR as soon as feasible. ADTMC protocol documentation is discussed further in appendix D.

4. Screener peer feedback will be completed on a monthly basis for medics who are working within the MTF for a cumulative period of two weeks (10 work days) within the last month or has screened 20 or more Soldiers.

a. Peer feedback will be conducted by another screener working within the clinic and will consist of evaluating 10 screening encounters, or all available encounters if less than 10 are available, that have been conducted by the screener for the following components:

1) Vital signs documented and any abnormalities identified.

2) History components documented to include chief complaint, additional history of present illness, medications, drug allergies, last menstrual period (all females).

3) Algorithm used documented and identification of key positives and negatives.

4) Disposition documented to include any medications, activity limitations, or patient education provided.

5) Consent and final timeout are documented if applicable (virtual medicine consent, procedural consent and final timeout).

b. If an issue is identified by the reviewer during the retroactive review of the documentation, the reviewer will immediately notify the supervising NCO. The supervising NCO will notify the supervising privileged provider with follow-on actions as discussed below.

c. If an issue is identified by the reviewer during a direct observation, all unsafe acts of care delivery will be immediately stopped and the reviewer will finish the screening and perform a debrief immediately following the incident. The supervising NCO will notify the supervising privileged provider with follow-on actions as discussed below.

d. The reviewer will provide the reviews to the supervising NCO after completion of the review and no later than one week after the end of the review time period. If an issue is identified by the reviewer during the retroactive review of the documentation, the reviewer will immediately notify the supervising NCO. The reviewer will discuss the reviews with the supervising NCO and will discuss any identified deficiencies and best practices.

5. Supervising NCO will completed on a monthly review of the consolidated data.

a. After the reviewers turn in the reviews to the supervising NCO, the supervising NCO will review them and compare them to their interactions with the screeners during sick call.

b. Any identified negative trends or issues will be provided to the supervising privileged provider along with the reviews and a recommended remediation plan.

c. The supervising NCO will provide both positive and negative feedback to the medic to ensure a thorough learning process. The supervising NCO will provide feedback weekly during the orientation process and then monthly after the medic has been authorized to utilize ADTMC protocol independently. Immediate feedback will be provided if a safety concern is identified.

6. Supervising privileged provider daily reviews are an integral part of the ADTMC protocol safety and quality control measures.

a. The supervising privileged provider is required to review and co-sign all ADTMC protocol notes daily when feasible. If it is not feasible to review the protocol notes on a daily basis, then the Soldiers seen will be verbally presented to the supervising privileged provider daily and the notes will be cosigned as soon as the notes are available for review.

b. Daily review of the screening notes will allow the supervising privileged provider to identify disease non-battle injury trends within the supported population and develop an understanding of the strengths and weaknesses of each screener.

c. Supervising privileged provider will use this review to ensure that the best quality of care is being provided to the screened Soldiers and identify areas to further develop their medics.

d. Supervising privileged provider will review all orders that the medics adds to the screening note as recommended by the protocol for review and concurrence and add the results of the labs or x-rays that have been completed as part of the ADTMC protocol to the screening note when they are resultd.

e. Supervising privileged provider will provide feedback to the medic immediately if a safety concern is identified, weekly during the orientation process, and monthly after the medic has been authorized to utilize ADTMC.

7. When a concern is identified by the supervising NCO or supervising privileged provider, the supervising NCO and supervising privileged provider will discuss whether remediation is needed.

a. If the medic in orientation is found to have repeated instances of not meeting the competency requirements, the supervising NCO and provider will discuss whether remediation is needed.

b. If the medic authorized to utilize ADTMC is found to have an instance of not demonstrating competency, the supervising NCO and provider will discuss whether remediation is needed.

c. If a remediation plan is required, it will be documented on a MFR by the supervising privileged provider.

d. The supervising provider will ensure, when appropriate, that concerns are elevated higher if deemed necessary and will handle these according to the facility, MEDCOM and Army policies and regulations as pertinent.

e. Concurrently, the supervising NCO and supervising privileged provider will also ensure items meeting reportable criteria for the Joint Patient Safety Reporting System (or system of record), will be completed at this time. This will ensure the involvement of the facility patient safety team of the event.

8. It is imperative that when there are identified issues and safety concerns with the medic performance in the ADTMC orientation program, that the supervising NCO and privileged provider concurrently discern if the event meets reportable criteria for a safety and/or sentinel event. This is completed separately from any formal review of the medic's performance or conduct, as safety and event reporting looks at the process of healthcare delivery (not the person).

a. All events that require reporting in the Joint Patient Safety Reporting System (JPSR), or system of use are as follows:

1) Those that do not reach the patient- in this category would be unsafe and near miss events.

2) Those events that reach the patient-this category includes no harm events and harm events. Harm events can be classified as mild, moderate, and severe (includes death).

b. Once the event is placed into the JPSR system (or system of use), the supervising NCO and supervising privileged provider will ensure collaboration with quality assurance and patient safety subject matter specialists to identify, analyze, and appropriately report these events through proper channels, to ensure we correct the process issue according to regulatory guidelines.

9. ADTMC protocol authority can be suspended by the supervising privileged provider and/or supervising medical director if a medic fails to successfully complete remediation. Also, if there are safety concerns raised with the medic's performance, the ADTMC authority can be revoked until further analysis of the concerns are addressed, analyzed and corrected.

a. When removing the screener's authorization to conduct ADTMC, the supervising privileged provider must notify the supervising medical director.

b. Actions related to the identified inappropriate behavior, safety concern, or ongoing remediation must be taken in accordance with AR 40-68, DODM 6025.13, or other existing regulation.

c. The supervising provider MFR granting the ADTMC protocol authorization will be removed from the screener's CAF and JCCQAS account.

d. A supervising provider MFR stating the reason that the ADTMC protocol authorization was removed and outlining the remediation plan will be placed in the Soldier's personnel record. The MFR will be maintained in the Soldier's local personnel record for a year after the incident has been resolved or longer if deemed necessary by supervising NCO, privileged provider or supervising medical director.

e. During the remediation period, an update will be provided to the medical director monthly of the progress that the screener is making.

f. Supervising medical director will add the monthly progress reports to the Soldier's personnel file.

10. If there are concerns of unethical or unprofessional conduct by the medic in patient care interaction/ delivery, HIPAA violations, drug diversion, or other deemed acts; these actions will be brought to the supervising NCO, privileged provider, and medical director for processing through the appropriate channels.

a. The supervising medical director will consult with legal authorities as appropriate and follow applicable personnel procedures so that due process proceedings, adequate notice, and fair hearing procedures are afforded to the involved personnel.

b. Soldier's authorization to provide medical care may be limited pending the results of an official investigation and commander's decision.

c. Actions will be in accordance with AR 40-68, DODM 6025.13, or other existing policy.

11. Re-instatement of a supervising privileged provider's delegation of the ADTMC protocol authorization:

a. Potential remediation programs include:

1) ADTMC protocol orientation and competency validation training program can be repeated in entirety from the beginning.

2) ADTMC protocol condensed orientation and competency validation training program can be utilized.

3) Increased frequency and/ or number of peer feedback reviews, direct supervision by an appointed authorized screener, or direct supervision of the supervising NCO can be used.

4) Alternative form of increased supervision as deemed appropriate by the group.

b. The increased supervision plan must be overseen by the supervising privileged provider and cannot be delegated to the supervising NCO.

c. Once the ADTMC protocol authorization has been reinstated, the new MFR providing ADTMC protocol authorization will be added to the Soldier's CAF folder and JCCQAS account.

Appendix F Virtual health

Virtual Health (VH) connects patients and providers to health care services across the world. Using VH, patients are able to receive care directly from remote providers via synchronous electronic communications such as clinical video-teleconferencing (VTC) or telephonic conferencing. This increases readiness, access to care, quality, and patient safety.

Provision of care guidelines for virtual health encounters:

1. Virtual health clinical guidelines.

a. Visits through VH Systems must meet the same basic standard of care and practice as those conducted either face-to-face (“brick and mortar” location) or via a Telephone visit based on the type of visit.

b. Providers will ensure the following provision of care measures are utilized based on the patient’s specific location.

1) Patient needs to be consented for VH visits.

2) Emergency procedures will be established prior to, or at the beginning of the VH visit. Those procedures will be based on the originating site which is where the patient is located. This is especially important for rotational, remote and deployed forces where there are often no organized clinic emergency functions, crash cart, etc.

3) The originating site medic must be present during the VH appointments to help ensure a safe environment and to be available in the event of an unexpected medical emergency.

4) Distant and originating site participants performing VH visits will discuss emergency back-up procedures at the beginning of the visit to include exchanging telephone numbers and the patient’s contact information including a physical address (for example, street address, town, building or apartment number).

5) If an emergency arises, the medic will initiate the emergency action plan and remain with the patient until emergency care services arrive. The distant site provider will remain connected to the patient and the medic until emergency care services arrive.

6) All clinical documentation is documented in the MHS EHR. Provider will use the “95” modifier for all mobile medic encounters in addition to the T1014 healthcare common procedure coding system (HCPCS) code for medical readiness support. If the medic and patient are located within an MTF, the provider will use the “GT” modifier instead of the “95” modifier.

2. Patient safety and risk management.

a. Treating a patient via VH requires additional safety measures including but not limited to some modifications in clinical operations.

b. If a VH patient requires hospitalization, the provider will coordinate with local MTF for admitting a patient and provide a warm handoff to the accepting provider. If a patient is sent to the local emergency department, the distant site provider will attempt to provide a warm handoff if possible.

c. The following are some potential emergency situations to consider when using VH services. The originating site must develop an emergency action plan (EAP) to address each situation (see the Virtual Health Encounter EAP example at the end of the annex).

1) A situation in which a patient decompensates quickly or has an unexpected medical complication during a routine VH appointment; while not originally an emergency, the situation becomes an emergency.

2) A situation in which a patient expresses suicidal/homicidal ideation/intention or expresses behavioral health concerns that need to be addressed by a behavioral health provider.

3) A situation in which a patient presents at the clinic as an emergency (for example, for an emergency evaluation). In this situation, it would not be recommended to utilize VH, but to follow local emergency management guidelines and the established emergency action plan.

d. All providers must be privileged at the originating site before conducting clinical VH encounters in accordance with OTSG/MEDCOM Policy Memo 17-041, Appendix F. If the originating and distant site are within the same MTF area of responsibility, no additional privileging is necessary.

e. Per AR 40-68, telemedicine encounters require written informed patient consent before the use of said technology using DA Form 4700 (Medical Record – Supplemental Medical Data). The informed consent documentation must be loaded into the MHS EHR within 48 hours of the encounter (appendix E).

f. All patient presenters and providers must complete VH training prior to participating in VH encounters. Additional training for VH is available online at <https://army.swankhealth.com>.

3. Virtual health provider roles.

a. Patient presenter (originating site) role - The primary responsibility for the patient's care lies with the distant site provider who is connecting virtually for patient treatment. The patient presenter assists the distant site provider with patient screenings, assessment and procedures within the scope of practice of the presenter. This applies to the medic or supervising NCO who is acting as or supporting the ADTMC screener.

b. Distant site provider role - The distant site provider who is connecting virtually to treat the patient has primary responsibility for the patient's care. At the beginning of the virtual appointment it is recommended that the distant site provider have a face-to-face discussion with the presenter about the patient's condition and determine what equipment is needed for evaluation of patient. Upon completion of the examination the distant site provider will discuss the findings and treatment plan with the presenter and patient.

4. Special considerations for choosing patients for VH - Exclusionary criteria include (but are not limited to):

- a. Refusal to participate in VH.
- b. Acutely violent, unstable, impulsive, or agitated behavior.
- c. Need for special monitoring/care not available at the originating site.
- d. Symptoms that could be exacerbated by VTC.
- e. Information which should be shared in person (for example, HIV positive).
- f. Hearing, visual, or cognitive deficits that limit the patient's ability to fully participate.

5. Facility guidelines: Where to conduct VH appointments.

A VH link can be set up virtually anywhere there is an internet connection. However, the location you select for the originating site can have a great impact on the quality of the VH visit. Ideally, VH encounters with patients will be in a clinic setting with an exam table, but this is not possible in all environments. The chosen room/area should maximize comfort, audio and visual privacy, and confidentiality while facilitating clinical interactions. DO NOT conduct a VH encounter in a noisy work or public setting. Providers are trained that they reserve the right to cancel the appointment if he or she feels that the environment is not appropriate to discuss protected medical information or conduct an examination.

6. Virtual health encounter EAP.

a. The originating site VH presenter will follow all policies and procedures in accordance with the originating site EAP for emergency situations. If an emergency arises during a virtual health encounter, it is the originating site's responsibility to initiate the EAP and call 911 for emergency assistance. If necessary, the distant site provider will provide a warm hand-off to the emergency department accepting the patient or other accepting privileged provider.

b. VH providers should not be relied upon to assist patients with emergent and/or after-hours issues (unless otherwise specified in the originating site SOP and coordinated with the distant site). MTFs are responsible for assisting patients with emergent and after-hours issues in accordance with site specific protocols.

c. Instructions:

1) The originating site presenter will activate the emergency procedures and protocols to ensure patient safety. If the originating site is located outside of an MTF, the presenter will call 911 and provide the operator with the physical address and a good call-back number in case the call is disconnected. The presenter will use basic life support (BLS) to provide aide to the patient as necessary and remain connected to the emergency operator (if possible) until emergency services arrive.

2) The distant site provider will remain connected virtually and provide assistance, when possible.

3) The VH Provider will complete relevant documentation in the patient record in the MHS EHR and sign/close the encounter immediately to ensure clinical documentation is readily available in the MHS EHR. The provider will then complete a patient safety report (PSR) and clearly indicate that this was a VH encounter.

4) The VH provider and presenter(s) will participate in an after-action assessment to review the course of action taken and identify any potential areas for process improvement.

5) The Virtual Medical Center and local MTF will review all patient safety reports and make adjustments to operating procedures as needed.

6) The Patient Safety Reporting System will be completed for all appropriate patient safety events. PSR's will be completed at the local MTFs and contact will be made with the Virtual Medical Center to provide notification of the safety event by sending an email to usarmy.jbsa.medcom-bamc.mbx.vmedcen-communications@mail.mil.

7. Training requirements.

a. Telehealth training: There are two (2) required on-line VH video training modules for VH providers and supporting personnel: 'Connect & Communicate' and 'Policy & Procedures.' (<https://army.swankhealth.com/>). Additional role-specific training is listed below.

b. Provider training:

- 1) Virtual health encounter coding.
- 2) Dos and don'ts during the VH encounter.

c. Patient presenter (ADTMC screener) training:

1) MHS EHR.

- Booking procedures.
- VH Patient requirements
- Note format
- Patient profile format

2) VTC system.

- Connecting to wireless/wired internet.
- Ensure access to and a working knowledge of all VTC programs (Jabber, global video services (GVS), ACANO).
- Introduction to all systems (Jabber, GVS, ACANO).
- HIPAA compliance (to include the use of VTC, security data).
- Identify the differences for conducting a patient encounter in both the Garrison environment and the Deployed setting.

3) Swank health.

- Complete all MTF related courses in Swank health.
- Complete and current in all MOS related/required swank health courses.
- Complete Tele-Health course in Swank health (required).

4) Competency assessment folders/ MOS-specific competencies.

- Current and compliant with all CAF requirements to include ADTMC screening competency and supporting Memorandum for Record.
- Maintain tracking of MOS- required training and competencies

- Licensures are up to date and current (licensed practical nurse (LPN); emergency medical technician (EMT); BLS)

8. Technology components.

a. Medical Communications for Combat Casualty Care (MC4) or any other Computer - Jabber accounts must be created through the DHA Video Network Center and the software must be loaded onto the computer being used. When connecting between an originating and distant site, the participants will create a secure, point-to-point, encrypted, VTC session. This is an on-demand capability that does not require pre-coordination of the virtual health encounter.

b. Multifunction HD general exam camera with tongue blade, variable polarizing and dermatology hood attachments.

1) HD image quality.

2) The variable polarizing hood expands its capability.

3) The modular heads, combined with a broad range of focus, allows the camera to be used in a wide range of applications where clear, precise images are essential.

c. Digital stethoscope. Superb audio clarity and quality, with more than 100x amplification, and can use any high quality audio headphones. Able to record to a file and forward, if the application is loaded on the computer. Device uses the conference audio channel for transmission; the stethoscope acts as a simple external microphone. Simple audio jack connection to computer.

d. Tele-electrocardiogram (ECG). Complete and full-featured 12 lead PC cardiology system. The unit is portable, durable, reliable and easy to use. Able to store ECG and forward for official read or complete during a synchronous visit with specialty care. The unit is MHS EHR compatible.

9. How to connect to synchronous video capability from an external location.

a. Cisco jabber.

1) Requirements:

- Jabber account and associated Webcam (Tandberg HD webcam).
- Computing device with Cisco jabber app installed.
- Network Access (Reliable Wi-Fi or Local Area Network [LAN]).

2) Prior to encounter.

- Perform initial log-in to jabber account.
- Set internal and external server addresses on the log in screen.
- Perform test call a few days prior to any encounters, if possible.
- Prior to the VTC encounter with a given provider, conduct a systems check and review emergency protocols.
- Check the quality of room lighting and patient positioning.
- Performing VH encounter.
- When ready to start the VTC encounter, escort the patient into the room and explain the equipment (camera, monitor and microphone). Note: Do not allow patient to operate video equipment.
- Instruct the patient to turn “off” their cell phone. Even a vibrating phone can be disruptive. Adjust the ringer on the room phone to the lowest setting.
- Place a sign outside the room stating: “Patient Video Teleconference in Session” (or similar language).
- Search for desired provider account and initiate call.
- Introduce patient to the provider and conduct a brief communications check (that is, “can you see/hear them o.k.?”). Make necessary volume/focus adjustments, etc.
- Present the patient to the provider.
- During the encounter, exam cameras can be used by accessing the settings menu and selecting the desired camera from the drop down menu.
- Once desired camera is selected ensure that you enable the camera within the call.
- Upon completion of exam, return settings to original configuration and continue visit or preform additional exams as needed.
- To use the digital stethoscope, access the audio settings and select device from dropdown menu. When done auscultating, return audio settings to original configuration.

3) After the encounter.

- Have patient fill out a patient survey. The survey can be completed in the waiting room while any required paperwork is being processed.
- Follow-up on with provider for any special requests that may need to be coordinated by presenter.
- Provider documents the virtual encounter in the MHS EHR using 95 modifier.
- Ensure proper documentation and coding of the patient VTC encounter in the MHS EHR at the distant site (provider’s documentation) with HCPCS code T1014 for medical readiness support.
- Troubleshooting issues.
- For issues with camera, first check that equipment is plugged in to proper ports and configured for use.
- Verify jabber video/audio settings appropriately reflect camera/audio devices desired.

- Verify internet connectivity is fast enough to support VTC communications (512kbs UL/DL).
- If unable to resolve issue contact local network or VTC support staff.

b. Global Video Services (GVS) Desktop Client by Defense Information Systems Agency (DISA).

1) As DISA's modernized internet protocol (IP)-based VTC service, GVS provides a full suite of on-demand, high-quality, assured video conference capabilities for users to interact visually within the Non-secure IP Router Network (NIPRNet) and the Secret IP Router Network (SIPRNet). GVS offers a desktop video solution, allowing face-to-face meetings from the desktop.

2) Both presenter and distant provider must have a GVS account.

3) Use of GVS is limited to DOD Network. If you are not on the DOD Network, you must use VPN to connect to GVS.

4) For more information on GVS capabilities, account request, desktop client installation and use, go to <https://www.disa.mil/Enterprise-Services/Video/GVS-Desktop-Client>.

Emergency Action Plan Example:

XXXnd MEDICAL BATTALION EMERGENCY ACTION PLAN

MEDICAL EMERGENCIES:

When NOT in a Virtual Health Encounter

1. In the event of a medical emergency, the mobile medic closest to the patient will check for responsiveness.
2. Perform Lifesaving measures.
3. Identify a mobile medic/team member/Soldier to call **911** and provide the emergency operator with exact location and building number/fob courage.
4. Notify respective platoon sergeant of the emergency.
 - An AED is located at the _____.

During a Virtual Health Encounter

1. In the event of a medical emergency during a virtual health encounter, the patient presenter will perform steps 1-4 and take additional guidance from the virtual health provider.

OTHER EMERGENCIES:

Bomb Threats, Active Shooter, and Fire Emergencies

1. Follow XXXnd MED BN SOPs.
2. The mobile medic team leader is responsible for taking accountability of the mobile medic personnel.

SECTION VI – POTENTIAL RISKS OF USING TELEHEALTH SERVICES

1. Delays in medical evaluation and treatment could occur due to equipment transmission delays or failure.
2. Security measures such as the use of a private network and an encryption tool have been taken to ensure that your PHI is protected and not accessed by unauthorized users. Healthcare providers cannot guarantee but will use reasonable means to maintain the security and confidentiality of the information sent and received via telehealth.

SECTION VII – ADDITIONAL INFORMATION

LEGALITY OF CONSENT IS DETERMINED BY THE LAW OF THE STATE IN WHICH THE FACILITY IS LOCATED, UNLESS PREEMPTED BY FEDERAL LAW OR AS MODIFIED IN OVERSEAS LOCATIONS. ANY ADDITIONAL STATE-MANDATED LANGUAGE CAN BE PLACED IN AN ATTACHMENT TO THIS DOCUMENT.

SECTION VIII – COMPLETE THIS SECTION FOR RECORDING OF VTC ENCOUNTER NOT APPLICABLE

1. On some occasions, certain procedures may be audiotaped, videotaped, or observed. This may include diagnosis, treatment, follow-up, and/or patient education regarding your medical care.
2. The purpose of this practice is to ensure the provision of high quality services through supervision of the work and/or use in the ongoing program of professional training at this medical center.

Patient Location (Hospital or Facility Name): _____

Referring Provider (Name/Title): _____ Location: _____

Telehealth Service Provider (Name/Title): _____ Location: _____

SECTION IX – PATIENT ACKNOWLEDGEMENT AND AGREEMENT

1. I have read and understand the information in this authorization form. I consent to having medical services provided by telehealth.
2. My healthcare provider has explained the alternative methods of medical care that may be available to me and the likely benefits and risks associated with these alternatives to deliver care in my situation. I have had any additional questions answered to my satisfaction.
3. By signing this form, I acknowledge the advantages and disadvantages associated with using telehealth services and authorize my health care providers to arrange telehealth services for the purpose of providing medical advice, diagnosis, education, consultation between providers, and/or treatment.
4. I understand that I have the right to revoke this authorization in writing at any time.
5. If "Recording Telehealth VTC" is checked in Section II, I consent to, and authorize the production of, auditory recordings, videotape recordings, closed circuit television, or other recorded observations. I understand that all materials and information will be handled strictly in accordance with professionally accepted standards of ethics and confidentiality.

Patient Signature: _____ Date: _____

Relationship of Patient Guardian/Parent (if other than patient): _____ NOT APPLICABLE

Witness Signature: _____ Date: _____

Advising Signature: _____ Date: _____
(Referring provider or authorized representative)

Appendix G

Orientation and competency validation training program

1. ADTMC protocol system is based on the delegation of the authority to perform certain routine tasks as outlined within the ADTMC protocol from the supervising privileged provider to the ADTMC screener through the supervising NCO. The delegation of the authority by the supervising privileged provider allows the unlicensed assistive personnel to perform these tasks. The supervising privileged provider remains responsible and accountable for the task, function, or process that has been delegated, and for the patient outcomes. It is critical that the supervising privileged provider ensures that the screeners are trained and competent to perform the duty prior to them being validated to act as an independent screener.

2. ADTMC protocol orientation and competency validation training program will encompass a cumulative four week clinical validation time period that incorporates 36 hours of didactic instruction. Clinical competencies must be revalidated:

a. Every 2 years.

b. Upon the screener moving to a new location.

c. If the supervising privileged provider at the current location changes, it is recommended that the current certified screeners at the location be re-validated by the new supervising privileged provider. New supervising privileged provider is responsible for the care that the authorized screeners provide. Supervising privileged provider may utilize a condensed competency validation training program for the current validated ADTMC protocol screeners in this situation.

d. If there are non-licensed personnel that are functioning as ADTMC screeners as outlined in this pamphlet within the previous six months by the time of the publishing of MEDCOM Pamphlet 40-7-21, then the supervising privileged provider may use this previous supervised time as the clinical validation time period or any part thereof.

3. Condensed orientation and competency validation training program will be conducted over no less than one cumulative week clinical revalidation time period. During the clinical revalidation time period, each currently certified screener that is getting revalidated must screen at least 20 Soldiers. Soldiers screened should represent the diversity of medical conditions covered in the ADTMC protocols. Screener will present each screened Soldier to the supervising privileged provider. 36 hours of didactic instruction is not required.

4. Clinical validation time period supplements the instruction through clinical experience while working within a primary care setting and provides an opportunity for the supervising privileged provider to validate the screener's clinical competencies prior to

being delegated the authority to screen independently. During the clinical validation time period, the training screener will:

a. Utilize ADTMC protocol system during sick call screening under the direct physical supervision of a validated ADTMC protocol screener, validated supervising NCO, or supervising privileged provider. Training screener must appropriately screen at least 80 Soldiers. Soldiers screened should represent the diversity of medical conditions covered in the ADTMC protocols.

b. Utilize the MHS EHR or DA Form 5181 to document screening encounters. Each encounter will be reviewed by the validated ADTMC protocol screener, validated supervising NCO, or supervising privileged provider prior to the Soldier leaving the screening area.

c. Communicate necessary physical limitations and document based on the local standard operating procedures or protocols.

d. Demonstrate competency in educating patients on minimal care protocols to include medications, exercise programs, and when to seek for further medical care.

e. Screen Soldiers for follow-on supervising privileged provider appointments. Remain in the room to observe the remainder of the encounter and assist the supervising privileged provider as needed.

f. Assist the supervising privileged provider with any procedures that are completed on Soldiers that training screener assisted with.

g. Document appropriate information on patient consent and final timeout forms, and provide appropriate patient counseling about procedures that the training screener assisted with.

h. Refer Soldiers directly to specialty care (physical therapy, dietician, behavioral health) when appropriate and specialty care providers accept self-referrals.

4. Didactic instruction is focused on utilization of the ADTMC protocol system and further developing the medic's foundation of clinical knowledge in common medical conditions encountered within primary care sick call. 36 hours of didactic training will be conducted to cover the main concepts utilized within the ADTMC protocol system. Training can be conducted through in-person or online classes as available. The following areas will be trained.

a. ADTMC protocol system (1 hour).

b. Readiness tracking systems to include electronic profile system (1 hour).

c. MHS EHR, DA Form 5181 , and SF 600 SOAP note documentation systems (one hour).

d. Pertinent local protocols and standard operating procedures (1 hour).

e. MEDCOM Regulation 40-50, 68W tasks that are utilized within ADTMC (all MEDCOM Regulation 40-50, 68W tasks except for 3.b.3.e-f and h; 3.b.6.8-10; 3.c.2.b,q, and u-w) (12 hours).

f. Medications within the pharmacy annex to include the indications, contraindications, potential side effects, and dosing (2 hours).

g. Common medical conditions encountered within primary care sick call (18 hours).

5. After completion of the cumulative validation or condensed revalidation time period, the supervising privileged provider may delegate the ADTMC protocol authorization through a MFR that is kept within the Soldier's CAF and uploaded into his or her JCCQAS account. MFR will accompany the ADTMC orientation and competency validation assessment form. Both forms are attached below.

ADTMC Orientation and Competency Validation Assessment Form

1. This evaluation report is to be used by the MTF staff to document the screener’s training. Section 2 and 3 must be **INITIALED** and **DATED** by the supervisor when a task has been completed. *Note:* a task may be initialed at different levels during the same rotation, but the **SIGNATURE** and **DATE** must be completed when the task is trained. **ALL TASKS SHOULD NOT BE SIGNED OFF ON THE SAME DAY.** Untrained means the Soldier missed the didactic portion of training and an opportunity for validation was not available. Partially trained means the didactic portion was completed. Trained means the knowledge/ skill competency was validated. It is the training screener’s responsibility to keep his or her competency assessment updated. A copy of this form will be placed in the Soldier’s CAF along with a copy of his or her memorandum for record if screening authority has been delegated to them.

2.

<u>Knowledge</u>	<u>Trained</u>	<u>Partially</u>	<u>Untrained</u>	<u>Not Observed</u>	<u>Sign & Date</u>
Electronic System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADTMC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury/ MACE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Red Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
URI/ Sinus Issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Interpret EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal Issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MSK Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heat/ Cold Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Travel Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic Reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Med Familiarization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

3.

<u>Procedures</u>	<u>Trained</u>	<u>Partially</u>	<u>Untrained</u>	<u>Not Observed</u>	<u>Sign & Date</u>
Vital Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glucometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oxygen Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluorescein Strip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Obtain Specimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IV, IVF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Splint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Treat Wart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sterile Field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Subungual Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Local Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
I&D Abscess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wound Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digital Block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paronychia I&D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toenail Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Final Certification

Primary Supervisor

Additional Supervisor

Additional Supervisor

(Rank, Name, Position)

(Rank, Name, Position)

(Rank, Name, Position)

(Signature/ Date)

(Signature/ Date)

(Signature/ Date)

ADTMC- Algorithm Directed Troop Medical Care	IV/ IVF- Intravenous/ Intravenous Fluids
MACE- Military Acute Concussion Evaluation	I&D- Incision and Drainage
URI- Upper Respiratory Infection	TO&E- Table of Organization and Equipment
EKG- Electrocardiogram	MODS- Medical Operational Data System
NREMT- National Registry of Emergency Medical Technicians	



REPLY TO
ATTENTION OF
OFFICE SYMBOL

DEPARTMENT OF THE ARMY
HEADQUARTERS, YOUR UNIT
UNIT ADDRESS
CITY, STATE XXXXX-XXXX

xx March 20xx

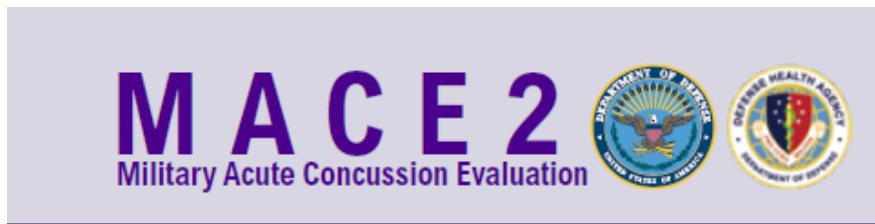
MEMORANDUM FOR RECORD

SUBJECT: SPC John/Jane Medic, xxx-xx-1234, Authority to Screen IAW MEDCOM Pamphlet 40-7-21

1. SPC John/Jane Medic completed his/her clinical validation time period from xxFebruaryxxxx to xxMarchxxxx and xxAprilxxxx to xxAprilxxxx. 36 hours of didactic training has been completed IAW MEDCOM Pamphlet 40-7-21 Algorithm Directed Troop Medical Care (ADTMC), Appendix F.
2. SPC John/Jane Medic's competency has been validated in the required knowledge and skills to implement ADTMC effectively and safely.
3. I, CPT John/ Jane Provider authorize SPC John/ Jane Medic to conduct sick call screening IAW MEDCOM Pamphlet 40-7-21 ADTMC. A copy of this memorandum will be kept within the Soldier's competency assessment file in the clinic with the Soldier's ADTMC orientation and competency validation assessment form. A copy of this memorandum will be uploaded into the Soldier's Joint Centralized Credentials and Quality Assurance System (JCCQAS) account.
4. This memorandum is valid until xxMarch20xx. (2 years form the date of the memorandum)
5. The point of contact for this memorandum is CPT John/Jane Provider at john/jane.provider.mil@mail.mil or (123) 456-7890.

JOHN/ JANE PROVIDER
CPT, MC/SP
BATTALION SURGEON

Appendix H Minor traumatic brain injury supplemental resources



Use MACE 2 as close to time of injury as possible.

Service Member Name: _____

DoDI/EDIPI/SSN: _____ Branch of Service & Unit: _____

Date of Injury: _____ Time of Injury: _____

Examiner: _____

Date of Evaluation: _____ Time of Evaluation: _____

Purpose: MACE 2 is a multimodal tool that assists providers in the assessment and diagnosis of concussion. The scoring, coding and steps to take after completion are found at the end of the MACE 2.

Timing: MACE 2 is most effective when used as close to the time of injury as possible. The MACE 2 may be repeated to evaluate recovery.

RED FLAGS

Evaluate for red flags in patients with Glasgow Coma Scale (GCS) 13-15.

- Deteriorating level of consciousness
- Double vision
- Increased restlessness, combative or agitated behavior
- Repeat vomiting
- Results from a structural brain injury detection device (if available)
- Seizures
- Weakness or tingling in arms or legs
- Severe or worsening headache

Defer MACE 2 if any red flags are present. Immediately consult higher level of care and consider urgent evacuation according to evacuation precedence/Tactical Combat Casualty Care (TCCC).

- Negative for all red flags**
Continue MACE 2, and observe for red flags throughout evaluation.

MACE 2 - Military Acute Concussion Evaluation

MILITARY ACUTE CONCUSSION SCREENING

Complete this section to determine if there was an injury event AND an alteration of consciousness or memory.

1. Description of Incident

A. Record the event as described by the service member or witness.

Use open-ended questions to get as much detail as possible.

Key questions:

- Can you tell me what you remember?
- What happened?
- Who were you last with?

B. Observable Signs

At the time of injury were any of these observable signs witnessed?

Visual clues that suggest a possible concussion include:

- Lying motionless on the ground
- Slow to get up after a direct or indirect blow to the head
- Disorientation, confusion, or an inability to respond appropriately to questions
- Blank or vacant look
- Balance difficulties, stumbling, or slow labored movements
- Facial injury after head trauma
- Negative for all observable signs

C. Record the type of event.

Check all that apply:

- Blunt object
- Sports injury
- Gunshot wound
- Fall
- Assault
- Explosion/blast
Estimated distance _____
- Fragment
- Motor vehicle crash
- Other _____

D. Was there a blow or jolt to the head?

- Did your head hit any objects?
- Did any objects strike your head?
- Did you feel a blast wave? (A blast wave that is felt striking the body or head is considered a blow to the head.)
- Did you have a head acceleration or deceleration?

YES NO UNKNOWN

MACE 2 - Military Acute Concussion Evaluation

4. History

A. During the past 12 months, were you diagnosed with a concussion, not counting this event?

YES NO

If yes, how many? _____

UNKNOWN

B. History of diagnosed/treated headache disorder or migraine.

YES NO

C. History of depression, anxiety, or other behavioral health concerns.

YES NO

CONCUSSION SCREENING RESULTS (Possible Concussion?)

Was there a blow or jolt to the head (1D)

AND

ANY alteration of consciousness or memory? (2A, 2B, 2C, or 2D)

YES (to both)



NO (to either or both)



POSITIVE CONCUSSION SCREEN:	NEGATIVE CONCUSSION SCREEN:
<ol style="list-style-type: none">1. Continue MACE 2.2. Complete evaluation before prescribing rest.3. Communicate findings to line leadership.4. Document and code findings in electronic health record (EHR).	<ol style="list-style-type: none">1. Stop MACE 2.2. Initiate 24 hour-rest period, if deployed. During rest, avoid activities that worsen symptoms. Follow up with the service member after rest period per concussion management tool (CMT).3. Communicate findings to line leadership.4. Document and code findings in electronic health record (EHR).

MACE 2 - Military Acute Concussion Evaluation

COGNITIVE EXAM

5. Orientation

Score one point for each correct response.

Ask This Question	Incorrect	Correct
"What month is this?"	0	1
"What is the date or day of the month?"	0	1
"What day of the week is it?"	0	1
"What year is it?"	0	1
"What time do you think it is?"	0	1
Correct response must be within one hour of actual time.		

ORIENTATION TOTAL SCORE

5

6. Immediate Memory

Choose one list (A-F below) and use that list for the remainder of the MACE 2.

Read the script for each trial and then read all five words. Circle the response for each word for each trial. Repeat the trial three times, even if the service member scores perfectly on any of the trials.

Trial 1 script: Read the script exactly as written.

- "I am going to test your memory. I will read you a list of words and when I am done, repeat back to me as many words as you can remember, in any order."

Trials 2 and 3 script: Read the script exactly as written.

- "I am going to repeat that list again. Repeat back to me as many words as you can remember, in any order, even if you said them before."

List A	Trial 1		Trial 2		Trial 3	
	Incorrect	Correct	Incorrect	Correct	Incorrect	Correct
Jacket	0	1	0	1	0	1
Arrow	0	1	0	1	0	1
Pepper	0	1	0	1	0	1
Cotton	0	1	0	1	0	1
Movie	0	1	0	1	0	1

IMMEDIATE MEMORY TOTAL SCORE

15

Immediate Memory Alternate Word Lists

List B	List C	List D	List E	List F
Dollar	Finger	Baby	Candle	Elbow
Honey	Penny	Monkey	Paper	Apple
Mirror	Blanket	Perfume	Sugar	Carpet
Saddle	Lemon	Sunset	Sandwich	Saddle
Anchor	Insect	Iron	Wagon	Bubble

MACE 2 - Military Acute Concussion Evaluation

NEUROLOGICAL EXAM

7. Speech Fluency

Normal

Abnormal

- Speech should be fluid and effortless – no pauses or unnatural breaks.
 - Stuttering or struggling to speak is abnormal.

8. Word Finding

Normal

Abnormal

- Assess difficulties with word finding:
 - Difficulty in coming up with the name of an object or grasping to find words is abnormal.

9. Grip Strength

Normal

Abnormal

- Assess grip strength. Grip strength should be strong and equal bilaterally.
 - Unequal or weak grip strength is abnormal.

10. Pronator Drift

Normal

Abnormal

- Direct service member to stand with eyes closed and arms extended forward, parallel to the ground with palms up. Assess for five to 10 seconds:
 - Any arm or palm drift is abnormal.

11. Single Leg Stance

Normal

Abnormal

- Remove shoes if possible. Have service member stand on one leg, arms across chest, hands touching shoulders, eyes open initially. Once service member is balanced, have them close their eyes and time for 15 seconds how long they can maintain their balance. Repeat test with opposite leg.
 - Loss of balance on either leg before eight seconds is abnormal.

MACE 2 - Military Acute Concussion Evaluation

NEUROLOGICAL EXAM - Continued

12. Tandem Gait

- Normal
- Abnormal

- Remove shoes if possible. Have service member take six steps one foot in front of the other, heel-to-toe, with arms at side
 - Stumbling or shifting feet is abnormal.

13. Pupil Response

- Normal
- Abnormal

- Pupils should be round, equal in size and briskly constrict to a direct, bright light.
 - Unequal pupil size, dilation or constriction delay is abnormal.

14. Eye Tracking

- Normal
- Abnormal

- Both eyes should smoothly track your finger side-to-side and up and down.
 - Unequal, irregular or delayed eye tracking is abnormal.

**NEUROLOGICAL
EXAM RESULTS
(Questions 7-14)**

All Normal

Any Abnormal

COGNITIVE EXAM

15. Concentration

A. Reverse Digits

Read the script and begin the trial by reading the first string of numbers in Trial 1.

Circle the response for each string.

- If correct on string length of Trial 1, proceed to the next longer string length in the same column.
- If incorrect on string length of Trial 1, move to the same string length of Trial 2.
- If incorrect on both string lengths in Trials 1 and 2, **STOP** and record score as zero for that string length. Record total score as sum of previous correct trials.

MACE 2 - Military Acute Concussion Evaluation

COGNITIVE EXAM - Continued

15. Concentration - Continued

A. Reverse Digits

Script: Read the script exactly as written.

- "I am going to read you a string of numbers. When I am finished, repeat them back to me backward. That is, in reverse order of how I read them to you. For example, if I said 7 - 1 - 9, then you would say 9 - 1 - 7."

List A		Incorrect	Correct
Trial 1	Trial 2 (if Trial 1 is incorrect)		
4-9-3	6-2-9	0	1
3-8-1-4	3-2-7-9	0	1
6-2-9-7-1	1-5-2-8-5	0	1
7-1-8-4-6-3	5-3-9-1-4-8	0	1

REVERSE DIGITS SCORE (16A)

4

Concentration Alternate Number Lists

Note: Use the same list (A-F) that was used in Question 6.

List B		List C	
Trial 1	Trial 2	Trial 1	Trial 2
5-2-6	4-1-5	1-4-2	6-5-8
1-7-9-5	4-9-6-8	6-8-3-1	3-4-8-1
4-8-5-2-7	6-1-8-4-3	4-9-1-5-3	6-8-2-5-1
8-3-1-9-6-4	7-2-7-8-5-6	3-7-6-5-1-9	9-2-6-5-1-4

List D		List E		List F	
Trial 1	Trial 2	Trial 1	Trial 2	Trial 1	Trial 2
7-8-2	9-2-6	3-8-2	5-1-8	2-7-1	4-7-9
4-1-8-3	9-7-2-3	2-7-9-3	2-1-6-9	1-6-8-3	3-9-2-4
1-7-9-2-6	4-1-7-5-2	4-1-8-6-9	9-4-1-7-5	2-4-7-5-8	8-3-9-6-4
2-6-4-8-1-7	8-4-1-9-3-5	6-9-7-3-8-2	4-2-7-9-3-8	5-8-6-2-4-9	3-1-7-8-2-6

MACE 2 - Military Acute Concussion Evaluation

COGNITIVE EXAM - Continued

15. Concentration - Continued

B. Months in Reverse Order

Script: Read the script exactly as written.

- "Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say: December, November...Go ahead."

Correct Response:

*Dec – Nov – Oct – Sep – Aug – Jul –
Jun – May – Apr – Mar – Feb – Jan*

	Incorrect	Correct
ALL months in reverse order	0	1

MONTHS IN REVERSE ORDER (16B)

CONCENTRATION TOTAL SCORE

Sum of scores:
15A (0-4 points) and 15B (0 or 1 point)

16. Delayed Recall

Read the script and circle the response for each word.
Do NOT repeat the word list.

Note: Use the same list (A-F) that was used in Question 6.

Script: Read the script exactly as written.

- "Do you remember that list of words I read a few minutes earlier? I want you to tell me as many words from that list as you can remember. You can say them in any order."

List A	Incorrect	Correct
Jacket	0	1
Arrow	0	1
Pepper	0	1
Cotton	0	1
Movie	0	1

DELAYED RECALL TOTAL SCORE

Delayed Recall Alternate Word Lists

List B	List C	List D	List E	List F
Dollar	Finger	Baby	Candle	Elbow
Honey	Penny	Monkey	Paper	Apple
Mirror	Blanket	Perfume	Sugar	Carpet
Saddle	Lemon	Sunset	Sandwich	Saddle
Anchor	Insect	Iron	Wagon	Bubble

MACE 2 - Military Acute Concussion Evaluation

17. Vestibular/Ocular-Motor Screening (VOMS) for Concussion Instructions

VOMS Contraindication: Unstable Cervical Spine.

Consider deferring VOMS if patient is overtly symptomatic or a trained provider unavailable. VOMS should be completed before return to duty. Use comment section for any provider-observed difficulty with specific VOMS tasks.

- A. Baseline symptoms.** Record headache, dizziness, nausea and fogginess (HDFN), on zero to 10 scale prior to screening.
- B. Smooth pursuits.** Service member and examiner are seated. Hold fingertip three feet from patient. Service member focuses on fingertip target as examiner moves fingertip smoothly horizontally one and a half feet right and left of midline at rate requiring two seconds to go fully from left to right and right to left. Perform twice. Repeat in vertical direction one and a half feet above and one and a half feet below midline up and down, moving eyes two seconds fully up and two seconds down. Perform twice. Record HDFN on a zero to 10 scale.
- C. Saccades.** Service member and examiner are seated.
 - 1) Horizontal saccades:** Hold two fingertips horizontally at a distance of three feet from service member, and one and a half feet left and right of midline so service member gazes 30 degrees left and right. Service member moves eyes as quickly as possible from point to point. Perform 10 times. Record HDFN on a zero to 10 scale.
 - 2) Vertical saccades:** Repeat with two fingertips vertically three feet from service member, and one and a half feet above and below midline so service member gazes 30 degrees upward and downward. Service member moves eyes as quickly as possible from point to point. Perform 10 times. Record HDFN on a zero to 10 scale.
- D. Convergence.** Service member and provider are seated facing each other. Service member focuses on font target (page 14) at arm's length and slowly brings toward tip of nose. Service member stops target when two distinct images seen or when outward deviation of eye observed. Repeat and measure three times. Record centimeters between target and tip of nose for each trial. A near point of convergence \geq five centimeters from the tip of the nose is considered abnormal. Record HDFN on a zero to 10 scale.

MACE 2 - Military Acute Concussion Evaluation

**17. Vestibular/Ocular-Motor Screening (VOMS)
for Concussion Instructions (Continued)**

- E. Vestibular-ocular reflex (VOR) test.** Service member and examiner are seated. Examiner holds font target (page 14) in front of service member in midline at three feet, rotation speed set with metronome.
- 1) Horizontal VOR test:** Service member rotates head horizontally focusing on target at 20 degrees to each side. Rotation = 180 beats per minute (bpm). Perform 10 times. Record: HDNF 10 seconds after test.
 - 2) Vertical VOR test:** Repeat test moving head vertically 20 degrees up and down at 180 bpm. Perform 10 times. Record HDNF 10 seconds after test.
- F. Visual motion sensitivity (VMS) test.** Service member stands with feet shoulder width apart, facing a busy area. Examiner stands next to and slightly behind service member. Service member outstretches arm. Focusing on their thumb, the service member rotates head, eyes and trunk as unit 80 degrees right and left. Rotation = 50 bpm. Perform five times. Record HDNF on a zero to 10 scale.

MACE 2 - Military Acute Concussion Evaluation

17. VOMS Score Card

Vestibular/Ocular Motor Test:	Not Tested	Headache 0-10	Dizziness 0-10	Nausea 0-10	Fogginess 0-10	Comments
BASELINE SYMPTOMS:	N/A					
Smooth Pursuits						
Saccades – Horizontal						
Saccades – Vertical						
Convergence (Near Point)						(Near Point in cm): Measure 1: _____ Measure 2: _____ Measure 3: _____
VOR – Horizontal						
VOR – Vertical						
Visual Motion Sensitivity Test						
Total						

Any score above baseline is considered abnormal

VOMS results

All Normal

Any Abnormal

MACE 2 - Military Acute Concussion Evaluation

EXAM SUMMARY

Record the data for correct MACE 2 documentation.

Cognitive Summary

Orientation Total Score - Q5

Immediate Memory Total Score (all 3 trials) - Q6

Concentration Total Score (Sections A and B) - Q15

Delayed Recall Total Score - Q16

COGNITIVE RESULTS

≤ 25 is abnormal

NEUROLOGICAL RESULTS (Q 7-14)

Abnormal (+) Normal (-)

SYMPTOM RESULTS (Q 3)

1 or more symptoms (+) No symptoms (-)

HISTORY RESULTS (Q 4A-4C)

Positive (+) Negative (-)

VOMS RESULTS (Q 17)

Abnormal (+) Normal (-) Deferred

MACE 2 RESULTS

Positive (+) Negative (-)

AFTER COMPLETING MACE 2:

- Document MACE 2 results in the EHR with coding instructions.
- Initiate 24-hour rest.
- Refer to concussion management tool for the management recommendations based on MACE 2 results.
- After 24-hour rest period, evaluate for initiation into the Progressive Return to Activity (PRA) following the guidance of the PRA Clinical Recommendation.

Refer to Progressive Return to Activity Clinical Tool at
dvbic.dcoe.mil/files/resources/2013_PRA_PCM_CST_FINAL.pdf

MACE 2 - Military Acute Concussion Evaluation

VOMS Equipment Sample 14 point font: **A**



TBI CODING INSTRUCTIONS

Initial TBI screening code*: Z13.850

TBI coding sequence:

1. Primary TBI diagnostic code: S06. E L S E**
2. Primary symptom code, if applicable: (e.g., H53.2 - diplopia)
3. Deployment status code, if applicable:*** (e.g., Z56.82 for deployed or Z91.82 for history of military deployment)
4. TBI external cause of morbidity code: (For example, Y36.290A (A- use for initial visit) for war operations involving other explosions and fragments, military personnel, initial encounter)
5. Place of occurrence code, if applicable
6. Activity code, if applicable
7. Personal History of TBI code: if applicable Z87.820

* MACE 2

** Etiology, Location, Severity, Encounter

*** Deployment code must fall within the first four codes when applicable

For more information, see DVBIC ICD-10 Coding Guidance Tool.

References available at <https://dvbic.dcoe.mil/material/military-acute-concussion-evaluation-2-mace-2-reference-list>.

We are authorized to collect the information on this form and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

THIS TOOL MAY BE COPIED FOR CLINICAL USE.

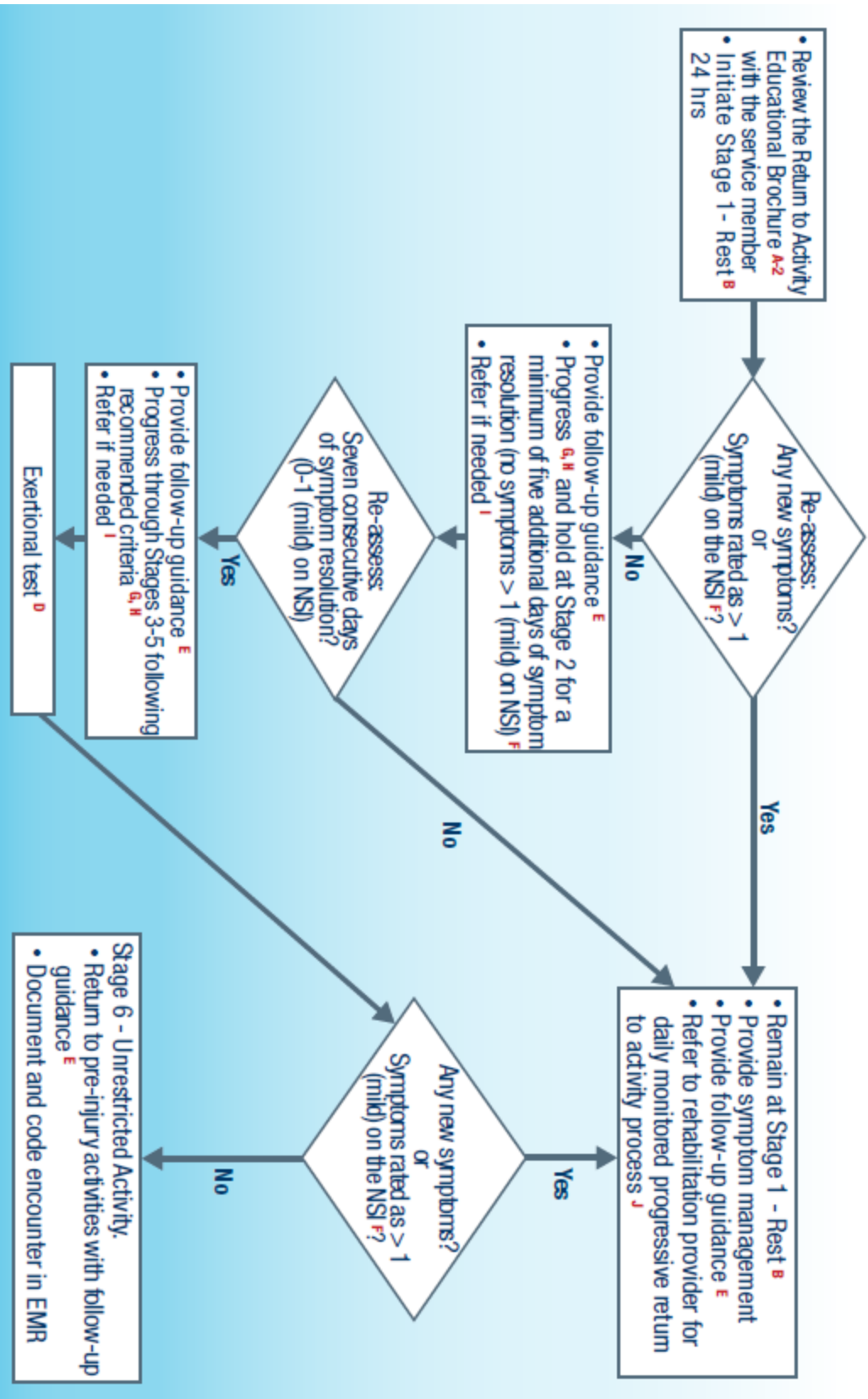
PUID 4901

Released: February 2012 | Revised October 2018
by Defense and Veterans Brain Injury Center.

This product is reviewed annually and is current until superseded.

Sidebar A - Progressive Return to Activity Following Acute Concussion/Mild TBI

Second concussion within the past 12 months



General Guidance:

After a mild TBI/concussion there is a 24-hour minimum recovery period.

Provide initial education for recovery using the Acute Concussion Educational Brochure.

After 24-hour recovery, if this is the first concussion in the past 12 months and service member is asymptomatic, exertional testing can be performed.

If the service member is symptomatic after 24 hours, or after exertional testing, or if this is the second concussion in 12 months, provide education using the Return to Activity Educational Brochure.

After the additional 24 hours in Stage 1, if this is the first concussion in the past 12 months and service member is asymptomatic, exertional testing can be performed.

The service member enters into the full progressive return to activity process if:

- they remain symptomatic after 48 hours or after exertional testing
- the current concussion is the **second in 12 months**

The service member completes the Neurobehavioral Symptom Inventory (NSI) daily, after each stage of progression.

Progress through one stage per day if symptoms are 0-1 (mild) on the NSI. Instruct the service member to return to the PCM if symptoms are reported as 2 or higher on the NSI.

When symptoms increase in number or severity during an activity the service member should stop the activity and rest for the remainder of the day. The following day, if symptoms are 2 or higher on the NSI, the service member should follow up with the PCM. If symptoms remain at 0 or 1 on the NSI, the service member may resume the previous day's stage. When repeating the previous day's activity, if there is an increase in symptom number and severity, the service member should follow up with the PCM.

A service member who sustains a **second concussion in 12 months** must have seven consecutive days of symptom resolution (defined as symptoms of 0-1 on the NSI) at Stage 1 and 2 before completing Stages 3-5.

Refer the patient to a rehabilitation provider or higher level of care per provider judgment or if:

- recovery is not progressing as anticipated
- there is no progression in seven days
- symptoms are worsening
- symptomatic after exertional testing following Stage 5

References

A-1. Acute Concussion Educational Brochure - dvbic.dcoe.mil

A-2. Return to Activity Educational Brochure - dvbic.dcoe.mil

B. Recommended Parameters for Recovery and Stage 1: Rest

<ul style="list-style-type: none"> Extremely light basic activities of daily living 	<ul style="list-style-type: none"> Avoid caffeine and tobacco
<ul style="list-style-type: none"> Wear comfortable clothing 	<ul style="list-style-type: none"> No exercise
<ul style="list-style-type: none"> Quiet environment with low lighting 	<ul style="list-style-type: none"> No alcohol
<ul style="list-style-type: none"> Healthy sleep - naps as needed 	<ul style="list-style-type: none"> No video games
<ul style="list-style-type: none"> Slow and limited range of motion 	<ul style="list-style-type: none"> No studying
<ul style="list-style-type: none"> Walk on level surface at easy pace 	<ul style="list-style-type: none"> No driving

C. Symptoms

<ul style="list-style-type: none"> Confusion (24 hrs) 	<ul style="list-style-type: none"> Irritability
<ul style="list-style-type: none"> Unsteady on feet 	<ul style="list-style-type: none"> Vertigo/dizziness
<ul style="list-style-type: none"> Headaches 	<ul style="list-style-type: none"> Photophobia
<ul style="list-style-type: none"> Phonophobia 	<ul style="list-style-type: none"> Sleep issues

D. Exertional Testing

<ul style="list-style-type: none"> Exert to 65-85% of target heart rate (THR=220-age) using push-ups, sit-ups, running in place, step aerobics, stationary bike, treadmill and/or hand crank
<ul style="list-style-type: none"> Maintain this level of exertion for approximately two minutes
<ul style="list-style-type: none"> Assess for symptoms (headache, vertigo, photophobia, balance, dizziness, nausea, visual changes, etc.)
<ul style="list-style-type: none"> If symptoms/red flags exist with exertional testing, stop testing, and consult with provider

E. Follow-up Guidance

<p>Instruct patient to follow up with provider if:</p> <ul style="list-style-type: none"> symptoms return symptoms increase in number and/or severity not able to progress for two consecutive days for first concussion

F. Neurobehavioral Symptom Inventory (NSI)

Rate 0-4

• Feeling dizzy	① ① ② ③ ④	• Loss of balance	① ① ② ③ ④
• Poor coordination, clumsy	① ① ② ③ ④	• Headaches	① ① ② ③ ④
• Nausea	① ① ② ③ ④	• Vision problems, blurring, trouble seeing	① ① ② ③ ④
• Sensitivity to light	① ① ② ③ ④	• Hearing difficulty	① ① ② ③ ④
• Sensitivity to noise	① ① ② ③ ④	• Numbness or tingling on parts of body	① ① ② ③ ④
• Changes in taste and/or smell	① ① ② ③ ④	• Loss of appetite or increased appetite	① ① ② ③ ④
• Poor concentration, can't pay attention, easily distracted	① ① ② ③ ④	• Forgetfulness, can't remember things	① ① ② ③ ④
• Difficulty making decisions	① ① ② ③ ④	• Slowed thinking, difficulty getting organized, can't finish things	① ① ② ③ ④
• Fatigue, loss of energy, getting tired easily	① ① ② ③ ④	• Difficulty falling or staying asleep	① ① ② ③ ④
• Feeling anxious or tense	① ① ② ③ ④	• Feeling depressed or sad	① ① ② ③ ④
• Irritability, easily annoyed	① ① ② ③ ④	• Poor frustration tolerance, feeling easily overwhelmed	① ① ② ③ ④

Key for Interpreting the NSI

0 = Rarely or never present. (None)
1 = Occasionally present but doesn't disrupt my activities. (Mild)
2 = Often present and occasionally disrupts my activities. I feel somewhat concerned. (Moderate)
3 = More frequently present and disrupts my activities. I can only do fairly easy, simple things. I feel I need help. (Severe)
4 = Almost always present. I can't perform at work, school or home because of it and I need help. (Very Severe)

Used with permission. Cicerone, K., Kalmar, K. (1995). Persistent post-concussion syndrome: The structure of subjective complaints after mild traumatic brain injury. The Journal of Head Trauma Rehabilitation, 10(3), 1-17.

G. Criteria for Progression

• Minimum of one day in each stage (24 hrs)
• No new symptoms
• Daily NSI symptoms reported as 0-1 (mild)
• If all criteria for progression are not met, return to previous stage for 24 hrs

H. What to do When Symptoms Occur

1. If symptoms increase in number or severity during an activity, the service member should stop the activity and rest for the remainder of the day.
2. The following day, if symptoms are 2 or higher on the NSI, the service member should follow up with the PCM. If symptoms remain at 0 or 1 on the NSI, the service member may resume the previous day's stage.
3. When repeating the previous day's activity, if there is an increase in symptom number and severity, the service member should follow up with the PCM.

I. When to Refer

Refer to rehabilitation provider or higher level of care per provider judgment, or if:

<ul style="list-style-type: none"> recovery is not progressing as anticipated
<ul style="list-style-type: none"> there is no progression in seven days
<ul style="list-style-type: none"> symptoms are worsening
<ul style="list-style-type: none"> symptomatic following exertional testing after Stage 5

J. Stages of Progressive Activity Following Acute Concussion/mTBI

Stages	Description	Objective
1.	Rest	Symptom resolution
2.	Light Routine Activity	Introduce and promote limited effort
3.	Light Occupation-oriented Activity	Increase light activities that require a combined use of physical, cognitive and/or balance skills
4.	Moderate Activity	Increase the intensity and complexity of physical, cognitive and balance activities
5.	Intensive Activity	Introduce activity of duration and intensity that parallels the service member's typical role, function and tempo
6.	Unrestricted Activity	Return to pre-injury activities

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**Defense Centers of Excellence
for Psychological Health and Traumatic Brain Injury
Defense and Veterans Brain Injury Center**

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dvvic.dcoe.mil | dcoe.mil

DCoE Outreach Center 866-966-1020

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Glossary

Section I Abbreviations

AD
active duty

ADTMC
algorithm-directed troop medical care

AEM
advanced enlisted medic

AMEDD
Army Medical Department

AMS
altered mental status

AR
Army regulation

BLS
basic life support

bpm
beats per minute

BSI
bone stress injury

CABG
coronary artery bypass graft

CAF
competency assessment file

CMDT
combat diving medical technician

CMT
concussion management tool

*MEDCOM Pam 40-7-21

DA

Department of the Army

DISA

Defense Information Systems Agency

DODM

Department of Defense Manual

DMO

dive medical officer

DP

decision point

EAP

emergency action plan

ECG

electrocardiogram

EHR

electronic health record

EMT

Emergency medical technician

GAS

Group A Streptococcal

GERD

gastroesophageal reflux disease

GI

gastrointestinal

GVS

global video services

hCG

human chorionic gonadotrophin

HCPCS

healthcare common procedure coding system

HEENT

head, eyes, ears, nose, and throat

HIV

human immunodeficiency virus

hrs

hours

HSV

herpes simplex virus

IP

internet protocol

JCCQAS

Joint Centralized Credentials and Quality Assurance System

LBP

low back pain

LMP

last menstrual period

LPN

licensed practical nurse

LUQ

left upper quadrant

MACE

military acute concussion evaluation

MEDCOM

United States Army Medical Command

MCP

minor-care protocol

MFR

memorandum for record

MHS

military healthcare system

*MEDCOM Pam 40-7-21

MRC

medical readiness category

mTBI

minor traumatic brain injury

MTF

military treatment facility

NCO

noncommissioned officer

NG

National Guard

OT

occupational therapy

PA

physician assistant

PI

process improvement

PO

by mouth

POR

preparation for replacements

PRN

as needed

PRP

personnel reliability program

PT

physical therapy

q (q6 hours)

every (every 6 hours)

RLQ

right lower quadrant

RUQ

right upper quadrant

SOP

standing operating procedure

STI

sexually transmitted infection

STP

Soldier training publication

TMJ

temporal-mandibular joint

TSWF

tri-service workflow

URI

upper respiratory infection

UTI

urinary tract infection.

USAR

United States Army Reserve

VH

virtual health

VOMS

vestibular/ocular-motor screening

VTC

video-teleconferencing

Section II

Terms

Occasionally the medical screener may be uncertain of the definition of some of the terms used in this pamphlet. The following glossary of terms is provided to provide further clarification.

Accountability. Being responsible for actions or inactions of self and others in the context of delegation.

Acne. A common skin condition occurring primarily in the late teens and early twenties but may continue into the thirties. Heredity, diet, hygiene, stress, and general illness can aggravate acne and be extremely upsetting to the young Soldier. Acne is caused by plugged oil glands. The oily material that is secreted develops a dark color when exposed to the air, forming what is known as a “blackhead.” These plugged glands may become inflamed, and pimples develop when bacteria begin breaking down the oil thereby producing irritating substances as by-products. With proper treatment, acne can be improved, thus avoiding scarring and lifelong side effects.

Advanced enlisted medic (AEM). Expeditionary combat medic, special operations medic, flight paramedic, or supervising NCO health care specialist or practical nurse specialist when local policy supports the delegation of authority from the supervising provider to the supervising NCO health care specialist or practical nurse specialist.

Asynchronous telehealth. Store-and-forward encounters that transmit medical images or information in one direction at a time via electronic communication. For example, a picture is taken of a skin lesion, sent to dermatologist with a clinical question and then an answer is sent back to sender at a later date.

Athlete’s foot. Athlete’s foot is the result of a fungal infection that usually starts with scaling and/or fissuring between the toes accompanied by intense itching. It is not uncommon for the infection to spread to other portions of the foot, especially around the toenail. The presence of athlete’s foot fungus can be confirmed by a potassium hydroxide test at the TMC.

Atrophy. Degeneration, wasting away.

Boil. Also known as a furuncle if it has a single “core”, or carbuncle if multiple cores. A painful nodule formed in the skin by inflammation enclosing a core. It is caused by bacteria which generally enter through a follicle. Tenderness, swelling, and pain are present around the area of redness. Extremely large or numerous boils can produce fever.

Burn. Any localized injury to the outer layer of skin caused by heat and characterized by redness, pain, and/or blisters. The three degrees of burns are:

- First Degree (characterized by redness).
- Second Degree (characterized by blistering).
- Third Degree (characterized by a leathery, whitish appearance; results when the outer layer of skin is destroyed).

Certification. Official recognition of an individual by a national agency or association that is intended to assure the public that the health care professional has successfully completed an approved educational program and evaluation. This includes a formal examination designed to assess the knowledge, experience, and skills requisite to the provision of high quality Soldier care in that specialty.

Chancere. The primary sore of syphilis characterized by an elevated painless ulceration which indicates the point of entry of the infection.

Competence. The ability to perform the duties, functions, and requirements of a particular discipline, job, or duty position as measured by meeting the following conditions: 1. Authorized to practice a specified scope of care under a written plan of supervision at any time within the past two years, or completed formal graduate professional education in a specified clinical specialty at any time within the past 2 years, or privileged to practice/authorized to provide a specified scope of care at any time within the past two years. 2. Actively pursued the practice of his/her discipline, job, or duty position within the past two years by having encountered a sufficient number of clinical cases or variety of experiences to represent a broad spectrum of the privilege requested or scope of care authorized. 3. Satisfactorily practiced the discipline as determined by the results of professional staff monitoring and evaluation relative to the quality and appropriateness of Soldier care.

Competency assessment file. A repository for a variety of relevant professionally oriented data and information that are accumulated throughout the individual's tenure in the organization. The CAF should contain information that relates to or may influence clinical performance; it is not a personnel or counseling folder. The first line supervisor maintains the competency assessment file for non-privileged health care personnel working within the AMEDD. See AR 40-68 for additional discussion of the CAF.

Confusion. A disturbance in the Soldier's understanding to the point that simple questions directed to the Soldier are not understood.

Conjunctivitis. Inflammation of the membrane that lines the eye and eyelids; also referred to as "pink eye."

Constipation. Infrequent or difficult bowel movements.

Constitutional. Affecting the entire body; not local.

Contact dermatitis (poison ivy). Results when the skin comes in contact with anything in the environment that causes an inflammatory reaction in the skin (for example, shoe materials, watchband, earrings, etc.). Poison ivy is the most common cause of contact dermatitis. The specific cause of the skin reaction in poison ivy is the oil secreted by the leaves. This oil can be transported directly from the plant to the skin by way of a

person's hand or even inhaled if the plants are being burned. A poison ivy rash is usually confined to the arms, legs, or face since these body parts readily come in contact with the plant. Symptoms usually develop within 24-48 hours of contact and are characterized by itching, redness, minor swelling, and the formation of blisters. The blisters can break resulting in oozing fluid and a crusted appearance. Contrary to popular belief, the fluid from broken blisters does not cause more lesions; only the plant oil can do that.

Contraception. The prevention of pregnancy.

Core competence. Possession of the knowledge, skills, and abilities necessary to fulfill the job responsibilities. Clinical competencies for each MOS/ASI are listed in appendixes A through H of this regulation.

Dandruff. A condition affecting the epidermal (outer) skin layer of the scalp characterized by itching and scaling of the scalp. More serious cases of dandruff can affect the facial areas as well.

Delegation. To entrust to another competent individual the authority to perform a selected task(s) in a selected situation(s).

Dermis. See **Skin.**

Diarrhea. Loose or liquid bowel movements of abnormal frequency.

Diastolic pressure. A measure of the blood pressure during the stage of dilation of the heart while it fills with blood; the low point of a blood pressure reading.

Diplopia. Seeing two images of a single object; double vision.

Distant (specialist/provider) Site. The location where the privileged provider is located.

Direct patient care activities. Those activities which assist the patient in various health care settings. This includes assisting with activities of daily living; therapeutic and diagnostic interventions; and collecting, reporting, and documenting data related to these activities.

Drug reaction (rash). An acute widespread temporary reddish eruption on the skin which can develop in individuals sensitive to a particular drug (prescription or nonprescription). The rash is characterized by itching that can interfere with sleep or performance of normal duties/activities. The rash results from the entire body reacting to the drug itself and usually develops early in treatment rather than after the drug has been taken for a period of time.

Dysphagia. Difficulty in swallowing.

Dysuria. Difficulty in or pain during urination.

Epidermis. See **Skin.**

Epistaxis. Nosebleed (normally resulting from the rupture of small blood vessels inside the nose).

Eustachian tube. Auditory tube, channel extending from the middle ear to the nasal passages.

Exudate. A substance found out of the normal or usual place deposited in or on tissue, usually resulting from inflammation.

Fatigue. State of increased discomfort and decreased efficiency resulting from prolonged or excessive exertion.

Fissure. A line-like crack in the skin.

Frostbite. The condition that results from the skin being exposed to extremely cold weather for an extended period of time (usually the toes, fingers, or face are affected). In severe cases, permanent destruction of tissues may occur from the crystallization of tissue water in the skin and adjacent tissues.

Gastroenteritis. Inflammation of the stomach and intestines.

Hair follicle. See **Skin.**

Hair loss. While most hair loss is natural and hereditary, any hair loss that is sudden or extreme in nature can result from a severe infection, caustic chemicals, or drugs. When treated promptly and properly, hair growth can resume.

Heat illness. The result of exposure to excessive temperatures with or without accompanying strenuous activity. The cause of heat injury is an excessive loss of water and salt from the body or a breakdown of the body's cooling mechanism.

Hematuria. Blood in urine.

Hemorrhoids. Expansion of one or more veins in the rectal area resulting from an increase in venous pressure.

Hypertension. Persistently high blood pressure.

Hyperventilation. Abnormally prolonged, rapid, and deep breathing causing an increased amount of air to enter the lungs resulting in a decrease in the level of carbon dioxide (CO) dissolved in the blood.

Immunologic. Pertaining to that branch of medicine dealing with the response of the body to the introduction of foreign substances (antigens) such as bacteria, viruses, and ragweed pollen.

Indirect patient care activities. Those activities necessary to support the patient and the environment of care such as preparing the patient for a procedure.

Jock itch (Tinea Cruris). Caused by a fungal infection and aggravated by sweating, restrictive garments, and a failure or inability to wash and *dry* carefully on a daily basis. This type of infection causes intense itching that can be disabling. In addition to intense itching, red areas with many small blisters and dandruff-like scales develop on either side of the scrotum. Spread of the infection beyond the groin area and involvement of the scrotum and/or penis is uncommon. A secondary bacterial infection *can* develop which can render the Soldier seriously ill.

Laryngitis. Inflammation of the larynx which may be accompanied by throat dryness, soreness, hoarseness, cough, and/or difficulty in swallowing.

Lesions. A wound, injury, or pathological alteration of tissue.

License. A grant of permission by an official agency of a State; the District of Columbia; or a commonwealth, territory, or possession of the United States to provide health care within the scope of practice of a specified discipline. Licenses must be--current. Active, not revoked, suspended, or lapsed in registration.

- Active. Characterized by present activity, participation, practice, or use.
- Valid. The issuing authority accepts, investigates, and acts upon quality assurance information, such as practitioner professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency.
- Unrestricted. Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction.

Malaise. A vague feeling of body discomfort.

Medical director (supervising). As used in this pamphlet, includes privileged medical personnel who are in a position that is responsible for and oversees the medical care of the medical personnel utilizing ADTMC and includes hospital deputies who are in charge of the care that is provided at the ADTMC screening location and department chiefs or clinic officers in charge dependent upon the level that the responsibility is

delegated down to and division surgeons and brigade or battalion surgeons dependent upon the level that the responsibility is delegated down to.

Medical officer. As used in this pamphlet, includes the following personnel: physicians, physician assistants, nurse practitioner, dentist, physical therapist, psychologist, clinical social worker, and dietitian, registered dietitian (RD) or registered dietitian nutritionist (RDN).

Meninges. The three membranes that surround the brain and spinal cord.

Menopause. Cessation of menstruation in the female, usually occurring between the ages of 46 and 50.

Menstrual period. The cyclic uterine bleeding which normally occurs in females at approximately four week intervals during the reproductive years in the absence of pregnancy.

Military treatment facility (MTF). As used in this pamphlet, MTF applies to all locations where treatment is performed to include TDA and TO&E medical locations in both the Active Duty, United States Army Reserves, and Army National Guard. MTF examples include an Army Medical Home, Soldier readiness processing (SRP) site, battalion aid station, or another sick call location.

Myalgia. Pain in a muscle or muscles.

Nausea. An unpleasant sensation that one may vomit (sick to the stomach).

Near Miss. An event or situation that could have resulted in harm to a Soldier but did not, either by chance or through timely intervention. The event was identified and resolved before reaching the Soldier. Such events have also been referred to as "close call incidents."

Neoplasm. Any new or abnormal growth (tumor). Everyone develops a neoplasm during his or her lifetime, but most neoplasms are not cancerous.

Originating (patient) Site. Where the Soldier is physically located.

Pap exam. A microscopic examination of cells to detect the presence of a cancerous process.

Patient Presenter. The person at the originating site who provides medical assistance and supports the distant site privileged provider in order to more extensively evaluate or assess the Soldier's condition during the VH encounter. The patient presenter is trained in the use of virtual health capabilities and peripheral equipment, and performs intake procedures and other initial hands-on

activities, (for example, range of motion, ear examination, breath and heart sound auscultation) as directed by the distant site privileged provider during the VH encounter.

Pediculosis (crabs). This condition affects hairy areas such as the groin, underarms, and scalp and is the result of infestation by tiny insects that are visible to the naked eye. The bite of the insect causes intense itching which can result in a serious secondary infection. The three forms of blood-sucking crabs' are--

- Head lice (pediculosis capitis).
- Body lice (pediculosis corporis).
- Pubic lice (pediculosis pubis) also known as "crabs."

Note: These insects require a diet of human blood. The adult insect will die a few days after removal from the body; nits must receive a blood meal within 24 hours of hatching or they too will die. The possibility of spreading infection to close associates by intimate contact or common use of clothing, beds, or toilet articles is real and should be considered.

Protocol. A written procedure providing basic guidelines for the management (diagnosis and treatment) of specific types of medical or dental patient care in specified circumstances.

Pseudofolliculitis barbae (shaving problem). A chronic condition characterized by inflammation of the beard area resulting from reentry of the growing hair into the upper layer of the skin. It can occur in any male with curly hair. The genetic predisposition of the black male to tight coiling hair makes him highly susceptible to this condition. The most common locations for lesions are the face and neck. The lesions can be painful and interfere with shaving although they rarely become secondarily infected.

Qualified provider. As used in this pamphlet, includes healthcare non-privileged providers that have been trained, validated, and delegated the authority to work within the medical facility for the medical condition that is being encountered. It can include expeditionary combat medic, special operations medic, flight paramedic, or supervising NCO when local policy supports the delegation of authority from the supervising privileged provider to the supervising NCO.

Screener. Screener is an enlisted medic whose clinical competencies have been validated during a competency validation training program by his or her supervising privileged provider, trained in the utilization of ADTMC, and authorized to utilize ADTMC in the screening of sick call patients through a memorandum of record by his or her supervising privileged provider.

Sebaceous gland. See **Skin.**

Skills Validation. Recognition by the AMEDDC&S HRCoE/MTF of the competence of an individual who has met predetermined qualifications and the authorization of the individual to perform certain procedures for which he or she has been trained or are otherwise qualified.

Skin. The skin is the largest organ of the body and its main duty is to protect man from the external environment. As a result of our constant exposure to a potentially harmful environment, diseases of the skin are common in all occupations and can cause many forms of disability.

Principle structures of the skin

1. **Horny layer (stratum corneum).** The outer layer of the skin. This outer layer is composed of dead, tightly-packed layers of cells that develop in the deeper layers of the skin, have moved upward, and are slowly being rubbed off or shed. This layer of dead skin is watertight thus protecting the body from water seeping in and out of the body.

2. **Epidermis.** Composed of living cells which, as they mature, serve as a constant renewal source for stratum corneum. The epidermis contains the pigment cells which determine skin color. The epidermis does not contain blood vessels, hair roots, or sweat glands. Damage to this layer does not result in scarring, but chronic or repeated damage can alter the number of pigment cells in the layer resulting in an overall change in the color of the skin. An example of this effect is a suntan. The darker color is a result of an increase in the pigment cells following injury of the epidermis by the ultraviolet rays of the sun.

3. **Dermis.** The supporting layer of the skin containing blood and lymph vessels, sweat glands, and hair follicles. Injury to the dermis can often result in bleeding. Found in the dermis are—

a. **Hair follicles.** Originate deep in the dermis and are composed of tightly-packed cells serving to support the growth of the hair shaft. Injury to either the dermis or deeper layers can cause death of the hair follicle and result in the absence of hair after the injury heals.

b. **Sweat glands.** Are also located deep in the dermis and are capable of secreting salt and water which rise up through the dermis and epidermis to the surface of the skin through pores. Evaporation of this sweat is part of the body's natural cooling process.

c. **Oil glands (sebaceous glands).** Are connected to the hair follicle and have as a primary duty the secretion of an oily substance called "sebum." This sebum reaches the surface through the channel that the hair shaft occupies. This substance is not to be confused with sweat which is made up mostly of water.

4. **Subcutaneous tissue.** Situated beneath the dermis and filled with large arteries, veins, nerves, lymph gland, and supportive tissue. Within the subcutaneous layer, fat (adipose) tissue is distributed. Injury to this layer will always result in scarring. Injury or illness to the skin can involve any or all of these parts. Signs and symptoms of diseases of the skin depend on the degree of the injury or illness and the structures affected.

Skin Laceration. Caused by any injury that results in damage to the outer layer of skin. If the injury is to a portion of the skin carrying blood vessels or nerves, bleeding and pain often result. A skin laceration involving a puncture wound or animal/human bite may require a tetanus shot and is serious due to the possible spread of infection.

Soldier. In this pamphlet, Soldier refers to the active duty, United States Army Reserves, and National Guard Soldiers and cadets while serving on active duty or activated for training.

Spinal meningitis. Inflammation of the meninges of the spinal cord.

Stratum corneum. See **Skin.**

Subcutaneous tissue. See **Skin.**

Sunburn. Result of overexposure of the skin to sunlight and characterized by a general redness of the skin. Fair-skinned individuals are more prone to freckling and sunburn quickly and frequently. Repeated overexposure to the sun should be avoided as permanent skin damage characterized by atrophy, dryness, wrinkling, and discolored areas can develop.

Supervising NCO. The supervising NCO is a qualified provider that has been authorized to act as the supervising NCO by the supervising privileged provider. Minimum requirements to be able to be authorized to act as the supervising NCO are completion of a cumulative 480 hours of prior screening experience, competency in 68W level 10-30 tasks, and being currently authorized to act as an ADTMC screener. The supervising privileged provider will authorize the qualified NCO to act as the supervising NCO through a MFR that is placed in the supervising NCO's CAF along with the MFR authorizing them to act as an ADTMC screener and competency assessment.

Supervision. The process of reviewing, monitoring, observing, and accepting responsibility for the actions of the supervised non-privileged medic.

1. Direct Supervision. The supervising privileged provider is involved in the decision-making process and development of the plan of care. This may be further subdivided as follows:

a. Verbal. The supervising privileged provider is presented the clinical case and consulted for the clinical regimen of care before implementation.

b. Physically present. The supervising privileged provider is present physically through all or a portion of the patient care encounter.

2. Indirect. The supervising privileged provider performs retrospective review of selected patient medical records. Criteria used for review are related to quality of care, quality of documentation, and the authorized scope of practice. Indirect supervision includes counter signature of all medical entries, reports, and profiles and signature of all orders.

Sustainment. The provision of training to support the maintenance of core competencies (identified by the MOS and/or ASI Branch, AMEDDC&S HRCoE) and unit-specific skills.

Sweat gland. See **Skin.**

Synchronous telehealth. “Real time” encounters that use interactive, electronic communication exchange in at least two directions in the same time period. Privileged providers and patients using this modality can exchange medical information for the purpose of direct patient care, obtaining an expert opinion, receiving diagnostic support, and clinical counseling or education.

Systolic pressure. A measure of the blood pressure during which the blood is driven from the heart throughout the body to the extremities; the high point of a blood pressure reading.

Tinea versicolor. Common superficial fungal infection which appears on the chest, back, arms, and abdomen usually with no other symptom. A patient with this condition complains only of the unsightly yellowish-tan or brown scaly lesions which may be localized in small patches or cover large areas of skin. Normally, the rash is sharply demarcated. Affected areas do not tan and become more noticeable during the summer. The responsible fungus is abundant in warm moist climates.

Trauma. A wound or injury (whether physical or psychological).

Trench foot. Results from prolonged exposure to wet, cold foot gear or outright immersion of the feet at temperatures usually below 50°F. At 50°F, exposure of 12 hours or more will cause injury. A shorter duration of exposure is needed at or near 32°F. The duration of exposure needed for trench foot decreases as the temperature approaches freezing.

Trismus. Limited range of motion of the jaw or lock jaw. One potential cause is spasm of the muscles of mastication (chewing).

U.S. Army Health Readiness Center of Excellence. The academic accreditation organization that approves enlisted technical training and standards.

Vertigo. An illusion of movement; sensation as if the external world were revolving around the Soldier or the Soldier himself was revolving in space. Not to be confused with dizziness which is a feeling of unsteadiness.

Vesicle. Superficial elevations of the skin formed by free fluid beneath the skin layer as in a blister.

Video network center (VNC). Defense Health Agency (DHA) VNC also known as the “bridge”; the multipoint conferencing service center which provides the platform and technical support for VTCs at most MTFs in DHA. The DHA VNC provides VTC connectivity through traditional VTC endpoints along with the Cisco Jabber VTC software.

Wheeze. Musical, whistling sound produced by air forced through narrowed passages.

Terms of location

Anterior (Ventral). Pertaining to the front surface of the body or part.

Caudal. Pertaining to the tail end of the body.

Cephalic. Pertaining to the head or to the head portion of the body.

Deep. Not superficial; situated far beneath the surface of the body or part.

Distal. Part farthest from the point of attachment.

Inferior. Beneath or below some part of a structure.

Lateral. At or near the side surface of the body or part.

Medial. At or toward the midline of the body or part.

Midline. Along the line extending down the middle of the body dividing the body into right and left sides.

Pelvic. Pertaining to the basin-shaped ring of bones which supports the spinal column and rests upon the lower extremities.

Proximal. Part nearest to the point of attachment.

Substernal. Situated below the breast bone.

Superficial. Pertaining to the outer surface of the body or part.

Superior. Over or above some part of a structure.

Terms of Motion

Abduction. Movement away from the midline.

Adduction. Movement toward the midline.

Eversion. Turning outward (e.g., sole of foot away from midline).

Extension. Movement that results in a straightening of an extremity.

External (lateral) rotation. To rotate from the midline; outward rotation.

Flexion. Movement that results in a bending of an extremity.

Internal (medial) rotation. To rotate from the midline; inward rotation.

Inversion. Turning inward (e.g., sole of foot towards midline).

Pronation. Refers to hand and forearm movement; results in the palm of the hand facing backward.

Supination. Refers to hand and forearm movement; results in the palm of the hand facing forward.

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The proponent of this pamphlet is the Deputy Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-C, 2748 Worth Road, Fort Sam Houston, TX 78234-6010.

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